State Registrar

DHMH 17 Rev 1/2001

MD 20178

Prince triderick

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Intigach OIL

31. Date filed (Month, Day, Year)

#303

2007

32. Registrat's Signature

DOXO !

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** William Fishter 18, 2007 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery County If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1XM 2□F Months Days Hours 147-48-5653 55 Dec. 5, 1951 New Jersey **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ia or 28a-f show t be notified at 1 ☐ Yes 2X No Director MD Prince George's Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or Items 23a 8421 Grandhaven Avenue 20772 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates: Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed the M Jical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Office Supply Company 12 Business Manager 1 and 2 should be filed w Health and Mental Hygier # 27 Is marked other tt permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Fishter Beatrice Bohl ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8421 Grandhaven Ave., Upper Marlboro, MD 20772 lace of Disposition (Name of Mary Pate) 20c. Location - City or Town, State Randall L. Fishter (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 22. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Lee Crematory 2007 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 22. Name and Address of Facility Lee Funeral Home Calvert. P.A. Marchine 1 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tibrillation **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner cardiomyopathy Due to (on as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine sician and burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 ☐ Ectopic pregnancy Por in the past 12 months? Month signed by the at Id be detached for 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2□ No 1∐ Yes 1 ☐ Yes 26. Place of Death (Check only one)

P.O. Box 68760 Division or Vital Records, this certificate To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral

Hospital 24 hours a

lD

Be P funeral Certification:

25. Was case referred to medical examiner? 2**X**No 1 🗌 Yes

27. Manner of Death 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 6 ☐ Could not be 3 ☐ Suicide

4 ☐ Homicide determined

1 Inpatient 28a. Date of Injury (Month, Day Year)

28b. Time of Injury М

2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29a. Certifier

(Check only one)

29c. License number

29d. Date signed (Month, Day, Year) 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sung Lee M.D.

31. Date filed (Month, Day, Year) Takoma Park, Maryland 20912 7901 Maple Ave. Registre s Signati MAR 2 1

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** March 12:1 FUDL -OWE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 □ F 60 101-36-1951 Director June 18, 1946 New York Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 20901 United States 10704 Meadowhill Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2√ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than Pharmacist Pharmacy 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Fried Lena Fliesler ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Heath are Important: If Item 27 is any injury or other trau once. 20901 10704 Meadowhill Road, Silver Spring, MD Sharon M. Fried, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Method of Disposition Burial 2 Cremation 3 Removal from State Mt. Lebanon Cemetery : 03/25/07 Adelphi, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Fune al Service Licensi Torchinsky Hebrew Funeral Home Carroll St. NW. Washington, DC such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Physician/Medical Exam Division or Vital Records, P.O. Box 68760, physician the aftending properties of the second se as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death ed by the a 9 Unknown been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 2□ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? Yes 2 No certificate ? 1□ Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3□ DOA Certification: To 1 Yes 1 Inpatient this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deal 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 🗌 Yes 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 0 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

of death (Item 23a) (Type, Print)

30. Name and address of person who completed cause

1 HOVE

Ad

Year)

3

29c. License number 29d. Qate signed (Month, Day, Year)

20850

Nicole Vetere, M.D. 9901 Medical Center Drive, Rockville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month -30 A M **Physician** MARCH FLEMMING E 200 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ARROLL MOUNT HINY
If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Days Year)
Feb. 20, 1933 MOUNT AIRY EASANT HOME VIEW NURSING 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Washington D.C Months 1□M 2F 220-28-5864 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, it a Medical Examiner must be notified at 1 Yes 2 No Director Mt. Airy Carrol1 Maryland 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21771 4101 Old National Pike Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Ite any injury or other traumatic event, the Medical Executive 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No White Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 ♥ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private School Teacher Education 5+ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Marie Anna Dickinson Geoffrey VanClief Houghland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 763 Fairview Ave. Apt D Annapolis, MD 21403 Nancy M. Wallace - Sister 20b. Place of Disposition (Name of cometery, crematory or other place)
Baltimore Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/21/2007 Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licenses Mics 0 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) numbes SPINCH **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? death but not resulting in the underlying cause given Part II. Other significant conditions contributing to þ 1 Tes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 00 1 TYes 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dire 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 1 Natural 2 ☐ Accident 5 Pending 2 No 1 TYes investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 9501

30. Name and address of person who completed cause

Registrar's Signature

			For State Registrar	State of Ma	aryland / Dep		ealth and M	lental Hyg	•	11005
			Decedent's Name (First, Middle, and a second s	Last)		inioato oi t		2. Date of Deat		3. Time of Death
	Physici	an						Month	Day Year	10:15 A M
	/Medic		Ernest Galle 4a. Facility Name (If not institution, g			4b City Town or	Location of Death	MARCH	16, 2007 4c. County of Death	10:15 A
7	Examin	er						. 4. 0		O
			6914 Canyon 5. Social Security Number 6		e (In yrs. last birthday,	If Under 1 Year	tol Heigh	8 Date of Birth	9 Birth	George's
	Funeral Director		248-56-5086	1 XM 2 ☐ F	7 1 Yrs.	Months Days	Hours Min.	(Month, Day,		place (State or Foreign ntry)
	-		Usual Residence of Decedent		/1	l		May 15,	1935 Sout	h_Carolina
yland	MOI W		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
Mar		ğ	Maryland Prince	George's		Capit	ol Height			1 MYes 2 ☐ No
the	282	Director	10e. Street and Number	OCOLEGE B		10f. Zip Code	or nergin		0g. Citizen of What Cou	ntry?
wit	38 0	0	6914 Canyon 1	Drive			20743		United S	tates
deat	E E	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Race - Amen	can Indian,
after O	훈름	T.	1 ☐ Never Married 2 💢 Married	Armed Forces? 1 □XYes 2□! If Yes, Give	10			Hican, etc.)	Black, White,	
1215-0036 within 72 hours after death with the Maryland	18	þ	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	KOREAN	1 ☐ Yes 2 🟋 No	Specify:		Specify: B	lack
21215-0036 ad within 72 hours aff	natu Eca	Completed	15. Decedent's (Specify only highest	Education	16a. Dece	dent's Usual Occupa	ation	ina	16b. Kind of Business/In	dustry
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Maryland 2	a to the first	Be	17. Father's Name (First, Middle, La	st)			18. Mother's Name	e (First, Middle, M	Maiden Sumame)	
aryla should t	Ment	၉	Lineau F	loyd				Graci	ie Galloway	
2 sho	ni of Heelih and Mental Hygiene. : if Item 27 is marked other than "natural", or Items 23a or 28a-f show or other treumatic event, the Madical Examinat must be notified at		19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ng Address (Street a	and Number or Run	al Route Number,	City or Town, State, Zij	Code)
S pue	Heelth tem 27 i		Bertha M. Gal	loway/Wife	6914	Canyon D	rive, Car	itol He:	ights, MD	20743
S - S	e e e		20a. Mathod of Disposition	Dameuri from State	20b. Place of Disponentery, cre	osition (Name of matory or other place	9)	Date	20c. Location - City or T	own, State
Baltimore,	Department of I Important: If Ite any Injury or of once.		1 the Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		Harmony	Memorial	Park 3/23	3/2007	Landover	. MD
	Departmer Important any Injury once.		21. Signatu of Funeral Service Lic	ensee					ineral Home	,
n &	sny l		1/show T.	Tental	101	4001	Benning	Rd., NE	Wash., DC	20019
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused	the death. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
Phy	ysician		Immediate Cause (Final disease or condition	STROKE	19.					Onset and Death
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Ex	aminer				VASCUALR I	ISEASE				
		e	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	b	a consequence of).					
pet	unsit	듄	cause. Enter Underlying Cause (Disease or injury that initiated events	HYPERTE	NSION					
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	phy s the								1	
Sertine S	nding use a	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of deliv	erv
P.O. BOX	for a	ciai	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at		Ectopic pregnancy Other (specify)			Month	Day Year
j ş	y the	ıysi	9 Unknown	9□ Unknown						
HECOFGS, P.O. BOX 68 The law requires that the death certifica	ed b deta	by Physician/Med	Part II. Other significant condition	s contributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribute to t	he cause of death?
VITAL HECOLDS, sicion: The law requires t	sign d be	q p						1 □ Ye	s 2 No 3 Prol	bably 4 Ninknown
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	r, pag							perform 1 Yes 2	No 1 ☐ Yes	2□ No
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×	this al dir	은	1 Yes 2 No	1 🗀 Inpatie	nt 2 ER/Outpatie		4 Linuising no		nce 6 Other (Speci	fy)
DIVISION OF	After	lo	27. Magner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time o y Year) lnjury	Work		28d. Describe no	w injury occurred	
SIC	tor:	cat	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	he -			Yes 2 □ No			
N P	olrec Direc in by	Certification:	4 Homicide determine		ury - At home, farm, st c. (Specify)	reet, factory, office		281. Location (Sti City or Town	reet and Number or Rur. i, State)	al Route Number,
Jital L	within 24 hours after death. To the Funeral Director: After th			1		_				
Hospital	Fund Fund tely fi	ca	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis o	examination and/or in	h occurred at the tim vestigation, in my or	e, date and place, pinion, death occur	and due to the ca	use(s) and manner as s ate and place, and due t	stated. o the cause(s)
To the	vithin 2 To the Complet	Medical	One)	and manner sta	ited.					
£	3 F 0		29b. Signature and title of certifier	CM-las sa	0	# D20			9d. Date signed (Month,	
1			> Elignetta L	. Cropps N		# D30	020	M	ARCH 21, 20	· · · · · · · · · · · · · · · · · · ·
T	41		30. Name and address of person wh	no completed cause of d	eath (Item 23a) (Type	Print)				
1	1		ELIZABETH LIPTON			O IRVING	STREET N	WASHI	NGTON, DC 20	422/688
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signatura					
	Registr	ar	MAR 22 2007	Dien L	. Aprile					

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Iteme 23a or 28e-f show any Injury or other treumatic event, the Medical Examinar must be notified at once. Baltimore, Maryland 21215-0036

> **Physician** /Medical Examiner

within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

2"	1. Decedent's Name	(First, Middle	e, Last)						2. Date of Death Month Day Year			3. Time of Death		
an ,	Frederi	ck Edm	und Guy						Month March	23 2007		7:45A M		
al	4a. Facility Name (III	f not institution	n, give street and number)			4b. City, Town, or	Location of D	eath		4c. County of	c. County of Death			
er			Veterans Hor	ne		Char	Lotte H	lal]	L	St.	Mar	v's		
	5. Social Security N			e (In yrs. last b	irthday)	If Under 1 Year	If Under 24		8. Date of Birth			place (State or Foreign		
	214-30-3		1⊠M 2□F	81	Yrs.	Months Days	Hours N	Min.	(Month, Day, November	Year)	<i>Cou</i> i Mary	ntry)		
	Usual Residence of				1						1017	Idila		
	10a. State	10b. County		10c. City, Tox	wn or Loc	ation				10d. Inside City Limits				
ğ	Maryland	St.	Mary's		Clements						1 ☐ Yes 2 ☑ No			
ec	10e. Street and Nur	nber			10f. Zip Code						10g. Citizen of What Country?			
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era	11. Marital Status	Torre na	12. Was Decedent	Ever in U.S.	13 W	Vas Decedent of H		? (Spe	cify Yes or No-			can Indian,		
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Š	3 Widowed		If Yes, Give	••	1	☐ Yes 2⊠ No	Specify:			Specify:	Whi	te		
D D		15. Deceden		16:	a Deced	ent's Usual Occup	ation		1	6b. Kind of Bus	ness/lr	ndustry		
Completed by Funeral Director		ify only highe	st grade completed)		(Give F	kind of work done of	furing most of	f workii	ng	02. 14.110 01 000	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
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ပိ	12 17. Father's Name	(First Middle	l ast)						(First, Middle, M	laiden Sumame)			
Be									Agnes Abe					
2		Eugene G			M 0.4 10						4-1- 7	. 0- 1-1		
	19a. Informant's Na					g Address (Street				City or Town, S	rate, Zij	o Code)		
	Sarah J. P.		/ Niece			ox 24, Cle	ments, N			on Laurian C	in or T	our State		
	20a. Method of Disp 1 Burial 2		3 □Removal from State	cemet	ery, crem	atory or other place	1 1.191	rch	28	toc. Location - C				
	4 Donation			St. Jo	seph'	s Cemetery	1		20Ó7	lorganza,	Mary	71and		
	21. Signature of Fu	neral Service	Licensee	,		Name and Address Mattingley-		r Fu	neral Home	P.A.				
	Mici	raela	Karden	22)		P.O. Box 27			town, MD 2					
	23a. Part 1. Enter the	he disease, or	complications that caused only one cause on each li	the death. Do	not ente	er the mode of dyin	g, such as car	rdiac o	r respiratory arre	st,		Approximate Interval Between		
	Immediate Cause	(Final	Claim	ic K	٠٠٨	0. 01 6	~ ~	<	PL	11		Onset and Death		
	disease or condition resulting in death)	"	Due to (or as	a consequence	e of):	iey dis	Gase		siage.	7	-			
			Can	apcti	ve	Cay	dia.		stage yopa	Hay				
e	Sequentially list con if any, leading to in	nmediate	Due to (or as	aconsequence		Car	CIO	111	gopa	L PY	-			
声	cause. Enter Unde Cause (Disease or that initiated events	injury		conar	7 .	Artemi	dis	en	Ce.					
Exa	resulting in death)		Due to (or as	a consequence		1. 0.9	0,0				_			
- R			1. Atr	ial	1	z bri 11	ation	n						
lan/Medical Examiner			0.				-(110							
×	IF FEMALE:		23c. If yes, outcome	of pregnancy						23d. Date	ol deliv	ren/		
	in the past 12	months?		2 Fetal deal		Ectopic pregnancy Other (specify)				Mont		Day Year		
ysi	1 ☐ Yes 2 ☐ 9 ☐ Unknown		9□ Unknown			(speeny)								
by Physic	Part II. Other signif	icant conditie	ons contributing to death b	out not resulting	in the un	deriving cause giv	en in Part I.		23e. Did tob	acco use contrib	oute to	the cause of death?		
ğ	Per	nici		emia		,,			1□Ye	s 2□No 3	B ☐ Prol	bably 4 Munknown		
te	T . C ,	/ (•	OFFIIM		·			-	-				
Completed	hupe	r ten	nsion						24a. Was ar autopsy	24b. W	ere auto	opsy findings available ompletion of cause of		
ő	0 0	1d 6	-accinar	In.	far	ct iv	Brai	in	perform 1 ☐ Yes 2		ath?	2 Ŋ No		
Be (25. Was case refer examiner?	red to medica			1	- ''	-		Check only one	9)				
To	1 Tes 2	No	Hospital: 1 Inpati	ent 2 ER/C	Outpatient	3 DOA Oth	er: 4 🐼 Nursii	ng Hor	ne 5 Reside	nce 6 Other	(Speci	fy)		
	27. Manner of Deat	h 5 ☐ Pendir	28a. Date of Inju	y Year) 28b.	. Time of Injury	28c. Injur Wor	at k?	:	28d. Describe ho	w injury occurre	t			
atic	2 Accident	investi	gation		. ,		Yes 2 □ No							
tific	3 ☐ Suicide 4 ☐ Homicide	not be nined 28e. Place of In building, et	eet, factory, office			28l. Location (Str City or Town		or Rur	al Route Number,					
									2y 5. 1 QMII					
27. Manner ol Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date ol Injury (Month, Day Year) 28b. Time of Injury at Work? 1 Yes 2 No 28b. Place of Injury - At home, larm, street, factory, office 28b. Linjury at Work? 1 Yes 2 No 28b. Place of Injury - At home, larm, street, factory, office 28b. Linjury at Work? 1 Yes 2 No 28b. Linjury at Work? 28c. Injury at Work? 28b. Dime of Injury - At home, larm, street, factory, office 28c. Injury at Work? 28b. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 3 Depth of Injury - At home, larm, street, factory, office 28c. Injury at Work? 3 Depth of Injury - At home, larm, street, factory, office 28c. Injury at Work? 3 Depth of Injury - At home, larm, street, factory, office 28c. Injury at Work? 3 Depth of Injury - At home, larm, street, factory, office 28c. Injury at Work? 3 Depth of Injury - At home, larm, street, factory, office 28c. Injury at Work? 3 Depth of Injury - At home, larm, street, factory, office 28c. Injury at Work? 3 Depth of Injury - At home, larm, street, factory, office 28c. Injury at Work? 3 Depth of Injury - At home, larm, street, factory, office 28c. Injury at Work? 4 Depth of Injury - At home, larm, street, factory, office 28c. Injury at Work? 4 Depth of Injury - At home, larm, street, factory, office 28c. Injury at Work? 4 Depth of Injury - At home, larm, street, factory, office 28c. Injury at Work? 5 Depth of Injury - At home, larm, street, factory, office 28c. Linjury at Work? 5 Depth of Injury - At home, larm, street, factory, office 28c. Linjury at Work? 5 Depth of Injury - At home, larm, street, factory, office 28c. Linjury at Work? 5 Depth of Injury - At home, larm, street, factory, office 28c. Linjury at Work? 5 Depth of Injury - At home, larm, street, factory, office 28c. Linjury at Work? 5 Depth of Injury - At home, larm, street, factory, office 28c. Linjury at Work? 5 Depth of Injury - At home, larm, street, factory, office 28c. Linjury at Work? 5 Depth of Injury - At h							and due to the ca	use(s) and man	ner as :	stated.				
(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and and manner stated.							ue and place, ar	ia ane t	to the cause(s)					
29b. Signature and title of certifier 29c. License number 29d. Date signed							d. Date signed	(Month,	Day, Year)					
Parall Same D450							09	2	10	03/2).3	12007		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										-/5				
	110 H	nspit	WRd				Zin	00	Fred	dvick		MD 2067		
110 Hospital BC Km 205 Priv									100		-+	,		

State Registrar

31. Date filed (Month, Day, Year)

MAR 2 6 2007

			1 _ State	epartment of Health and M Certificate of Death	lental Hyg		11007
			Registrar 1. Decedent's Name (First, Middle, Last)	John Marie of Dours	2. Date of Deat	h	3. Time of Death
	Physic /Med		Terry Lee Gallo, SR.		Month 3	24 2007	3:00 A M
•	Exami		4a. Facility Name (If not institution, give street and number) Atlantic General Hospital	4b. City, Town, or Location of Death Berlin		4c. County of Death Worcester	
j	Funeral Director		210 02 3300	nday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 8/24/19	48 9. Birth Cou Mary	place (State or Foreign ntry) and
2	aryland show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
3	the Maryla 28a-f shor	ţō	MD Worcester Ocean	City			1 X Yes 2 □ No
2	death with the Maryland me 23a or 28a-f show fritual be notified at	Dire	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Cou	ntry?
R	e 23a	rai	114 78th Street, #C 11. Marital Status 12. Was Decedent Ever in U.S.	21842	orifu Voe or No-	USA 14. Race - Ameri	can Indian
୍ୟ ଅ	72 hours after de naturel', or Item	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No If Yes, Give	 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify: 	Rican, etc.)	Black, White,	
200	2 hou ature	ted		Decedent's Usual Occupation		16b. Kind of Business/Ir	ndustry
05	S - 3	npie	Elementary/Secondary (U-12) College (1-4015+)	Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired)	ng		
アトグ	filed with Hygiene. other than	ပိ	1. Father's Name (First, Middle, Last)	eral Manager	(First Middle A	Restaurant	
8/24/18 7/25/2 Maryland 21	s 1 end 2 should be filed with i Health and Mental Hygiene. Item 27 is marked other than other traumatic event, has	To Be	Vincent Gallo	Virginia	Smith		
S CO	d 2 sh th and 7 is rr traum			Mailing Address (Street and Number or Aura 78th St., Ocean Cit		, City or Town, State, Zi 21842	o Code)
1 1 0	Health tem 27		20a Method of Disposition 20b, Place of	Disposition (Name of	The second second	21042 20c. Location - City or T	own, State
DOB DOD	Pages ent of nt: if i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cape He	onlopen Crem. 3/25	/2007	Frankford,	DE
000 - 000 - Raltimore	permit. Pages Department of importent: if i eny injury or once.		21. Signature of Puneral Service Licensee	22. Name and Address of Facility The 108 William Street,	Burbage	Funeral Ho	
			23a. Part1. Enter the disease or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Firlat disease or condition	of Civer			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence or	1): 0 00			
			if any leading to immediate Due to (or as a consequence)	CHI/USE			
	ansit and	Examiner	cause. Enter Undertying Cause (Disease or injury				
	be executed sician and burial-transit		that initiated events c. Tesulting in death) Last Due to (or as a consequence or	f):			
3760	. 0 . 0	icai	d				
, x	ertifica ding pl	Med	IF FEMALE:				
7 200	a to	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year
000		ysic	1 Yes 2 No 9 Unknown 9 Unknown	3 Cuter (appeally)			
120 A	equires that the de een signed by the a rould be detached f	d by Physician/Medi	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did toil	bacco use contribute to es 2 No 3 Pro	the cause of death?
7.50	> 0 %	Completed			24a. Wasa		opsy findings available
Spra	9 2 9	E			autops perform	ned? death? 2 No 1 ☐ Yes	ompletion of cause of 2 No
9 K	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?	26. Place of Deat			
, , , ,	Physic this ce	2	1 Yes 2 No Hospital: Inpatient 2 ER/Out			ence 6 ☐Other (Spec	fy)
	ding F n. After funera	lon:		me of 28c. Injury at jury Work? M 1 ☐ Yes 2 ☐ No	28d. Describe ho	ow injury occurred	
P. S. Division	of attending Physician: after deeth. Director: After this certific d in by the funeral director.	ficat	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far			reet and Number or Rui	ral Route Number,
ي ج	s after in Dire	Certification:	4 ☐ Homicide Optermined building, etc. (Specify)		City or Town	n, State)	
tay to	To the Hospital or, within 24 hours after To the Funeral Direction completely filled in the complete of the co	edical	29a. Certifier (Check only one) Cartifying Physician: To the best of my knowledge, 2 Madical Examiner: On the basis of examination and and manner stated.				
14	To 11 To 11	Ž	29b. Signature and title of certifier)	29c. License number	2	9d. Date signed (Month	, Day, Year)
			of my	11064282		2/6410-	+
	BA2		30 Name and address of person who completed eause of death (from 23a) (14 Drive Be	lan m	1. 21811	
		tate	31. Date filed (Month, Day, Year) 32 Registrar's Signature	1-40		, 000	
	Regis	trar	MAR 2 6 2007 Boun B.	George .			

	will soledon	•	For State Registrar		rtment of Health and M tificate of Death	Reg. M	2001	11008
	Physici		1. Decedent's Name (First, Middle, Last) ELSIE GARNETT-JOHNSON	I		2. Date of Death Month MARCH 21	2007 ^{Year}	3. Time of Death 11:55 AM
V	/Medio Examin		4a. Facility Name (If not institution, give street and LAURELWOOD NURSING HO	ME	4b. City, Town, or Location of Death ELKTON		CECIL	
	Funeral Director		5. Social Security Number 220-18-5382 Usual Residence of Decedent	7. Age (In yrs. last birthday) 94 Yrs.	Months Days Hours Min.	8. Date of Birth 08/24/191	9. Birthp Coun	lace (State or Foreign try) VA
	Maryland -f show	tor	10a. State 10b. County MD CECIL	10c. City, Town or Lo	cation PEAKE CITY		1	0d. Inside City Limits 1 ☐ Yes 2X No
	with the	i Director	10e. Street and Number 176 CAYOTES CORNER RO)AD	10f. Zip Code 21915	10g. (US.	Citizen of What Coun	try?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiting hual by notified at ance.	by Funeral	Ame	d Forces?	Was Decedent of Hispanic Origin? (SpirYes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: BLA	etc.
Maryland 21215-0036	within 72 ho lene. r then *natur the Medical.	Completed	15. Decedent's Education (Specify only highest grade completed in the comp	(Give life.	ient's Usual Occupation kind of work done during most of work DO NOT use retired) BLY LINE WORKER	ring	Kind of Business/Ind	
land 2	uid be filed Aental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, Last) THOMAS GARNETT			e (First, Middle, Maid WASHINGTO		
, Mary	and 2 sho salth and N n 27 is ma		19a. Informant's Name/Relationship (Type, Print) PERCY GARNETT/NEPHEW		ng Address (Street and Number or Rur HORSESHOE CIRCLE,			Code)
Baltimore,	Pages 1. ment of He ant: if iten ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal for a □ Comparison 5 □ Other (Specify)		natory or other place)	Date 20c. 24/2007 CH	Location · City or To	
Balt	permit. Departitimport. any inj		21. Signature of Funeral Service Licensed	22	FELLOWS, HELFENB 130 SPEER ROAD,	EIN AND NE CHESTERTOW	WNAM FUNE N, MD 216	RAL HOME 20
Land I	Physician /Medical		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	nat caused the death. Do not ent on each line. Renaul faulu to (or as a consequence of):	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
**	Examiner	ner		type Leusi From to (d) as a consequence of):				
8760,	ficate be executed g physicien and is the burial-transit	ledical Examiner	that initiated events c.	is to (or as a consequence of):				
P.O. Box 68	law requires that the death certifica as been signed by the attending ph ? Shruid be detached for use as it	Physician/Med	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing	to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the	ne cause of death?
al Reco	The ate h page	Completed				24a. Was an autopsy performed 1 🗆 Yes	prior to co death?	psy findings available mpletion of cause of 2 No
Division of Vital Records,	ding Phys h. After this funeral di	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospitaf: 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 ER/Outpatient 2 ER/Outpatient 2 Bb. Time of Injury Month, Day Year)	nt 3 DOA Other: 4 Dursing H	th Check only one) ome 5 Residence 28d. Describe how in		у)
Divis	tel or Attendi rs after death. el Director: A ed in by the fu	Certi Ication:		Place of Injury - At home, farm, str unifding, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rura ate)	il Route Number,
	To the Hospitel or #8 within 24 hours after of To the Funerel Direct completely filled in by	edicai	(Check only 2 Medical Examiner: On to one) and		h occurred at the time, date and place vestigation, in my opinion, death occu-	rred at the time, date	and place, and due to	o the cause(s)
		Σ	29b. Signature and title of certifier	- 417	29c. License number	296.	Date signed (Month,	Day, Year)
	3		30. Name and address of person who completed	cause of death (ftem 23a) (Type,	Print) W. Main 5t	Elti	ton MN	2/92/
	در المراقعة Regist	ate rar	31. Date filed (Month, Day, Year) MAR 2 6 2007	32. Reginature	And of		-1 110	any 600

State Registrar 29b. Signature and title of certifier

1454

Day,

DEER

31. Date filed (Month,

15730921

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (VDASTAZ HOSTACE

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

			1 - For Stete Registrar	State of Maryland	-		nt of He			Reg. No	1001	11010
	Physici /Medio	al	Decedent's Name (First, Middle, Las WILBERT	GOODINE		45 675	Town of	Leasting of F	MAR(CH 15,	2007	3. Time of Death 10:55A M
	Examir	¥.	4a. Facility Name (If not institution, give 3610 WAYNES WOOD 5. Social Security Number 6. St	RD		FT.	WASH	Location of DINGTON If Under 24 Hours	Hrs. 8. Date Min. (Mon	PR of Birth oth, Day, Year		DRGE uplace (State or Foreign untry)
W.	Director		229-44-9738 Usual Residence of Decedent 10a. State 10b. County	69	Yrs.				04-1	8-1937	WASH	INGTON DC 10d. Inside City Limits
	h with the Mar 3a or 28a-1 e	al Director	MD PRINCE G 10e. Street and Number 3610 WAYNESWOOD R		WASHIN	10f. Zi	0774				itizen of What Cod	1X Yes 2 □ No untry?
036	should be filed within 72 hours efter death with the Maryland nd Menial Hyglene marked other than "naturel", or Items 23a or 28a-f ehow matic event, the Madical Examinat must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:	- 1	Was Dece If Yes, spe		spanic Origin , Mexican, P Specify:	i? (Specify Yes Puerto Rican, e	or No-	14. Race - Amer Black, White Specify: BLA	, etc.
21215-0036	d within 72 ho giene. or than "natur	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12th	ucation de completed) College (1-4or 5+)	life.	kind of wo DO NOT i	ork done di ise retired)	urina most of	_		Kind of Business/I	ŕ
g	ould be filed I Mental Hygin narked other natic event, ii	To Be C	17. Father's Name (First, Middle, Last) ROBERT GOODINE					LOREN	Name (First, M	IER		
e, Ma	1 and 2 st Health and em 27 is n		19a. Informant's Name/Relationship (CAROL GOODINE /WI	FE 20b. Pla	3610 ace of Dispo	WAYN	ESWOC	DD RD 1		HINGTO	or Town, State, Z N, MD 20 Location - City or 1	744
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked any Injury or other treumatic a <u>gnce</u> .		1	FT.	22	OLN C	EMETE	ERY 03	-22-200 JB JENK LANDOV	INS FU	NTWOOD, NERAL HO	
760,	Physician /Medical /Medical summiner parallel /Medical Examiner / (Lausit parallel / (Lau	ical Examiner	23a. Part1. Enter the disease, of composhock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CORONARY AR' Due to (or as a consequence course of coronary and the death.) b. CORONARY AR' Due to (or as a consequence death.) C. HYPERTENSIV. Due to (or as a consequence death.)	INFARO ence of): TERY I ence of): E CARI	CTION	de of dying	, such as ca	rdiac or respira			Approximate Interval Between Onset and Death
.O. Box 6	at the death certifica by the ettending ph stached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic p					23d. Date of deli- Month	very Day Year
Records, P.	v requires the been signed should be de	b	Part II. Other significant conditions o	ontributing to death but not resul	lting in the u	nderlying	cause give	n in Part I.		Did tobacco	No 3□Pro	the cause of death? bbably 4 □Unknown topsy findings available
ital Re		Be Completed	25. Was case referred to medical examiner?					26. Place of	-	autopsy performed? Yes 20 N	prior to death?	ompletion of cause of
Division of Vital	ing P	은	examiner; 1 □ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		28c. Injury Work	4 🗆 (40/5)	28d. Des	Residence scribe how inju	6 ☐Other (Specury occurred	rity)
Divisi	는 다음	Certification;	3 ☐ Suicide 6 ☐ Could not by determined	28e. Place of Injury - At hor building, etc. (Specify))				City	or Town, Sta	te)	ral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	ledicai	(Check only 2 Medical Exan	ysicien: To the best of my know niner: On the basis of examinati and manner stated.	vledge, deat ion and/or in	vestigation	n, in my op	inion, death	place, and due occurred at the	time, date ar	nd place, and due	to the cause(s)
	To with	M	29b. Signature and title of certifier	Jeng M.D		29	c. License	c 9 P	6	29d. D	2 - 16 -	
1	(10)		30. Name and address of person who VICTOR HERRY, MD	9131 PISCATAWA	AY RD	SUITI	E 240	CLINT	ON, MD	20735		
	Sta Regista		31. Date filed (Month, Day, 2007)	32. Registrar's Signat	BILL	ジ						

		1 - State Registrar		Cer	tificate of	Death	Mental Hy	Reg. No.	00/	1101
Physici /Medi Examir	cal	Decedent's Name (First, Middle, Last, George Cliff 4a. Facility Name (If not institution, give	ord Humbel		4b. City, Town, or	r Location of De	2. Date of De Month Mar.	24°,	2007 County of Death	3. Time of De
Funeral Director		Northampton Ma 5. Social Security Number 194-22-2679 Usual Residence of Decedent		g Home s. last birthday) Yrs.	Frede If Under 1 Year Months Days	rick If Under 24 H Hours Mi		alı	rederi 1929	ick pplace (State or Fo untry) PA
8a-f show	ector	MD 10b. County Freder		City, Town or Lo	Frederi	ck		10.00		10d. Inside City L
ns 23a or 2	Funeral Director	10e. Street and Number 7062 Basswood 11. Marital Status	Rd •	IIS 13 V	10f. Zip Code	21703			USA 14. Race - Amer	
ral, or item Examinar	ρ	1 Never Married Married 3 Widowed 4 Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No 19	ソノエコ	Was Decedent of H f Yes, specify Cuba i ☐ Yes 2X No		erto Rican, etc.)		Black, White	etc.
r than "natu the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 1.2		(Give	dent's Usual Occup kind of work done o DO NOT use retired printer	during most of width	vorking	fed	nd of Business/h leral vernmer	,
Mental mys larkad other latic avant,	To Be C	17. Father's Name (First, Middle, Last) Peter Hum				18. Mother's N	lame (First, Middle Lunz	, Maiden	Sumame)	
Department of health and Menhair rygener. Importent: If Item 27 is marked other than "natural; or items 23a or 28a-f show importent: If Item 27 is marked other than "natural; or item 23a or 28a-f show injury or other traumatic avant, the Madical Examiner must be notified at 2008.		19a. Informant's Name/Relationship (7) Corinne Humbel 20a. Method of Disposition 1 Byrial 2	(Wife)	7062 Place of Disposementery, cremuthera	Basswo sition (Name of natory or other plac n cemet Name and Addee Onald B O. Bo	od Rd. ery 3/	, Frede 28/2007 pson Fu	rick 20c. Lo Mid	c, MD 2 cation - City or T ddletov	21703 Town, State Wn, MD
/sician ledical		Immediate Cause (Final				3,				Approximate Interval Between
ysicien and wie burial-transit	Ical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.)	NSON (ENTE	iac or respiratory a		25	
ysicien and in	cal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of): equence of): equence of): equence of):		ENTE			23d. Date of delik Month	Interval Betwee Onset and Dea
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		artment of Health and Mertificate of Death	ental Hygiene Reg. No.	11012
	Decedent's Name (First, Middle, Last)		Date of Death Month Day Year	3. Time of Death
Physician /Medical	Thomas Raymond Hebb		March 24 2007	
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	ath
	St. Mary's Hospital	Leonardtown	St. Mary	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 M 2 F 62 Yrs.	Months Days Hours Min.	(Month, Day, Year)	rthplace (State or Foreign ountry)
Director	Usual Residence of Decedent		.0/22/1944 Mar	yland
yland	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
Mar Mar	Maryland St. Mary's Leonardto	own		1 X Yes 2 ☐ No
with the Mar t or 28s-f si	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	country?
ath wath was 23a	22785 Longmore Street	20650	United Stat	
5 r ritems 23s noncrouss Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- lican, etc.) 14. Race - Am Black, Wh	
D36		1 ☐ Yes 2 🛣No Specify:	Specify:	-1-
ind 21215-0036 be filed within 72 hours after death with the Maryland to Hygiene. d other then "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at Be Completed by Funeral Director		edent's Usual Occupation	16b. Kind of Busines	Lack s/Industry
21215-00 ed within 72 hou ygiene. Per then "neture it, the Medical Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)	g	
2 g g g r	8 Highw	ay Maintenance	County Gov	vernment
Po in the little of the little	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maiden Surname)	
Tyla nould 1 Men narke natic		Mary Fran		
Baltimore, Maryland 21215-0036 Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Heelih and Menallar Hygiene. Deperment of Health and Menallar Hygiene. In mitocraft: If them 27 is marked other then "natural", or thems 23a or 28a-1 show eny Injury or other treumatic event, the Medical Examinar must be invitilled all page. To Be Completed by Funeral Director		ing Address (Street and Number or Rural		
Te, 1 an Heel	20a Method of Disposition 20b. Place of Disp	Box 43 Loveville	Maryland 20656	
TO Dages and of the control of the c	De Buriar 2 (1) Cremation 3 (1) Removal nom State	Momorial Com 02/20	1/2007 I como milhoco	- MD
22/	J. O. Maries	Memorial Cem. 03/30 2. Name and Address of Facility Bri		
Baltimo Baltimo Permit. Page Deperment of importants if eny Injury or once.		22955 Hollywood Roa		
	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate Interval Between
Physician	Immediate Cause (Final disease or condition	REHYTHMIA		Onset and Death
/Medical Examiner	resulting in death) Due to (or as a consequence of):	[44] + [1111		
	Sequentially list conditions, b. HYPOXIA			MINUTE:
nslt nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	REJAL DISEASE		MINUTE: YEARS
8760, sate be executed hysicien and the burial-transit	that initiated events resulting in death) Last Due to (or as a consequence of):	ILEMAN DIRECTOR		IENKS
\$760, safe to the physicien the burial Edical Edica	d			
OMAS Geath certificate death certificate e attending p ad for use as	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy	23d. Date of de	
O. B. Be death he atterned for selcia	in the past 12 months? Section 2 Pregnant at time of death 5	Other (specify)	Month	Day Year
S, P.O. Box 6 set thet the death certificated by the attending to detached for use as by Physician/Me.	9 Unknown		002 Bid to be seen to	
of Vital Records, P.O. Physician: The law requires that the rhis certificate has been signed by the rail director, page 2 should be detached: TO Be Completed by Physician in the complete phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute	Probably 4 Unknown
HEBB A Record The law requir cate has been si pege 2 should	<i>I</i> .			2.3
166			24a. Was an autopsy performed2 death?	autopsy findings available completion of cause of
Vital Filtian: The certificate rector, page	25. Was case referred to medical		1 Yes 2 No 1 Ye	s 2 No
Ystcian: Tystcian: Secritical director. Po Be Co	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 R/Outpatie	26. Place of Death	(Check only one) se 5 ☐ Residence 6 ☐ Other (Sp	
g Physic er this c eral dir.	27 Magner of Death 28a. Date of Injury 28b. Time	THE SELECTION ACTIONS	8d. Describe how injury occurred	өспу)
Vision of Attending Is of Gath. Fector: After by the fune full	Natural 5 Pending (Month, Day Year) Injury	M 1 Yes 2 No		
Division of the or Attending P is either deally ellorector. After leed in by the funer certification;	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Souicide 4 ☐ Homicide	treet, factory, office 2	8f. Location (Street and Number or F City or Town, State)	Rural Route Number,
Display or us effective Display in the Display is effective Cert				
To the Hospital within 24 hours of To the Funeral completely filled	29a. Certiflier (Check only one) Certifying Physician: To the best of my knowledge, dea (Check only one) Certifying Physician: To the best of my knowledge, dea (Check only one) And manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	nd due to the cause(s) and manner a d at the time, date and place, and du	as stated. se to the cause(s)
To the within Z To the comple	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mor	oth, Day, Year)
	MD	DOORSUS	March 2	7005 P
(2)	30. Name and address of person who completed cause of the little (Item 23a) (Type	, Print)		
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	LEONARDTOWN	MD SOLSO	
Registrar	MAR 2 8 2007	order .		

			For State Registrar	State of IV	iaiyiaii		rtificate of		ia ivie		g. No. 20	07	11(013
	Physicia	an	1. Decedent's Name (First, Middle						2	. Date of Death Month	Day	Year	3. Time of	
	/Medic		Beatrice 4a. Facility Name (If not institution	B. n. give street and number		Hite	4b. City, Town, o	r Location of		March 2	0, 200 4c. County		7:45	рм
)	Examili	ei 	Hillhaven Nur				, , , , , , , , , , , , , , , , , , , ,	Adelph			1		Georg	e's
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. I	last birthday)	If Under 1 Year Months Days	If Under 24		. Date of Birth (Month, Day,			place (State or	
d	Director		234-01-2805 Usual Residence of Decedent	10 M 20 X		94 Yrs.			1	n. 11,			Virgi	
	land ow		10a. State 10b. County		10c. City	, Town or Lo	ocation					1	0d. Inside Cit	y Limits
	Mary Fied a	tor	Maryland Montg	omerv		Si	lver Spri	ina					1 ☐ Yes	2₩No
	th the or 28% e noti)irec	10e. Street and Number	Omoly		<u> </u>	10f. Zip Code	ing		10	g. Citizen of V	What Cour	ntry?	
	ath wi	Funeral Director	2203 Falling	Creek Road			2090				USA			
	er des items ner m	nne	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	12. Was Deceden Armed Forces ried 1 ☐ Yes 2¥	?	S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origii an, Mexican,	n? (Specif Pu <i>er</i> to Ric	y Yes or No- can, etc.)		e - Americ ck, White,		
0020	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. we marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	þ	3 Widowed 4 Divorced	1/ 1/ 00			1 ☐ Yes 2 ☐ No	Specify:			Specify	Whi	te	
5	72 hou	Completed	15. Deceden	t's Education st grade completed)		16a. Dece	dent's Usual Occup	ation	of working	1	6b. Kind of Bu	usiness/Inc	dustry	
V	ithin The.	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retired	d)	n working					
7	iled w Hygiel ther ti		17. Father's Name (First, Middle,	1 1			Bookkee		n Namo /f	First, Middle, M			it Uni	on
	d be f antal l ced of	o Be	Holly H. Benn	,						Staats	aiueii Suinaii	ne)		
چ	shoul nd Me mark	ပို	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street				City or Town,	State, Zip	Code)	
Ě	and 2 ealth a n 27 is ier trau		Ellen Horner/	Daughter		2203	Falling	Creek	Road	, Silve	er Spri	ng, M	D 2090	4
2	of He of He filter		20a. Method of Disposition 1 Burial 2 □ Cremation	3 DRemoval from State	20b. P	lace of Dispo emetery, crei	osition (Name of matory or other place n Cemeter	ce)	Date	-	0c. Location -	City or To	wn, State	
Dallillo	tment of trant: If Ite		4 Donation 5 Dother (S	pecify)	ra.			i	arch 2007		plain ,	West	Virgi	nia
Da	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee		1º 5	ramens ^{Addre} 00 Univer	ss comiy; sity E	ins F 31vd,	uneral W., Si	Home I	nc. Sprin	g, MD :	2090:
Š			23a. Part1. 3 ter the disease, or shock, heart failure. List	complications that cause only one cause on each	he death	. Do not ent	er the mode of dyin	ng, such as ca	ardiac or r	espiratory arres	st,		Approximate Interval Betw	veen
ì	Physician		Immediate Cause (Final disease or condition	_a Stroke									Onset and D	
	/Medical Examiner		resulting in death)	Due to (or as	678 em - 2	CASAL VIII								
i	A MA	e.	Sequentially list conditions, if any, leading to immediate	b. Atrial Due to (or as			on		_				10 Yea	ars_
	uted d ansit	Examiner	Cause (Disease or injury that initiated events											
5	e exectan and and and and and and and and and a		resulting in death) Last	Due to (or as	s a consequ	ence of):								
0070	cate b	Medical		d										
2	certific	Me	IF FEMALE:	23c. If yes, outcome	e of pregna	ncv					00 t D-1			
ם ם	death a atter	Physician//	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 4 ☐ Pregnant	2 🗆 Fetal	death 3	Ectopic pregnancy Other (specify)	/				te of delive onth	-	'ear
į	t the c by the	hysi	9 Unknown	9□Unknown										
'n	es tha gned be det	>	Part II. Other significant condition Hypertension, De							23e. Did toba	icco use cont	ribute to th	ne cause of de	eath?
5	requir			- Con	igesti	ve ne	it railu	те	- 1	1 ☐ Yes	2 □ No	3 Prob	ably 4 📈 0	nknown
פֿר	e law has b	Completed							_	24a. Was an autopsy	/ /	prior to cor	psy findings a npletion of ca	vailable use of
<u></u>	n: Th ficate r. pag		05.14								ĽNo .	death? 1 □ Yes	2□No	
>	rsicial s certi lirecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ient 2 🗆 I	ER/Outnation	nt 3 DOA Oth	or:		Check only one,				
5	g Phy ter this neral o	H	27. Man, er of Death	28a. Date of Inj	ury	28b. Time of Injury				5 Resident 1. Describe how	_		/)	
5	endin ath, or: Aff he fur	atio	1 Natural 5 □ Pending 2 □ Accident investig	gation	ay rear/	mjary		Yes 2 □ No	,					
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	3 Suicide 6 Could r 4 Homicide determ	inod Zoe. Flace of In	jury - At ho tc. <i>(Specify</i>	me, farm, str	eet, factory, office		28f.	Location (Stre City or Town,	et and Numb State)	er or Rura	l Route Numb	oer,
	popital hours a meral y filled		29a. Certifier 1 Certifyin	ig Physician: To the besi	t of my know	wledge, deat	n occurred at the tir	me, date and	place, and	d due to the cau	use(s) and ma	anner as si	tated.	
	the He in 24 the Fu	Medical	(Check only 2 Medical one)	Examiner: On the basis and manner s	of examinat	ion and/or în	vestigation, in my o	pinion, death	occurred	at the time, da	te and place,	and due to	the cause(s)	
	To To	2	29b. Signature and title of certifie	200011	\sim	1 ~	29c. License		-4		d. Date signed			
	10		your	march	100	V		1938	1		3/01	10	/	
	/0		30. Name and address of person Robyn Andersor				Print) Drive,	#205,	Silve	er Spri	ng, Ma	rylar	nd	
	Stat		31. Date filed (Month, Day, Year)	32. Egist	rar's Signat	ture	nach s		~					
	Registra		THE PARTY AND A			7 Fo // M	2004G/G/F/ #							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Elsie Rebecca Holland 1915 /Medical Mar 17, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🔀 F Director 212-78-0428 97 Oct 1, 1909 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Director MD Calvert **Owings** 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 390 Skinners Turn Road 20736 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 🔀 No Specify Specify: Black 9 3 Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Own Home 6 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Wallace Aleatha Giles ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma Howard /Daughter P.O. Box 735 Owings, MD 20736 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 03/24/07 Friendship, MD Carter's UM Church Cemetery 21. Signature of Funeral Service Licens 22. Name and Address of Facility Gladys Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respiratory **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 9☐Unknown P.O. I 5 ☐ Other (specify) ed by the a detached f 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 2 1 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA this neral Director: After this filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑ Natural Certification: 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

JABER State

29b. Signature and title of certifier

MD

100 HOSPITAL RO.

and manner stated

060390

29c. License number

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRINCE FREDERICK MD 20678

Registr MAR 2 1

DHMH 17 Rev 1/2001

State Registrar

		•	101	partment of Health and Ment ertificate of Death	al Hygiene	7 11015
	Physici /Media	an cal	1. Decedent's Name (First, Middle, Last) GERALD KNEISLEY IRVING	MÄ	ate of Death fonth Day Yea ARCH 22 2007	7:15 P ^M
	Examir	ć.	4a. Facility Name (If not institution, give street and number) Washington County Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 ☑ M 2 ☐ F	Months Days Hours Min. (A	ate of Birth 9 F	eath INGTON Sirthplace (State or Foreign Country) 1ARYLAND
	Director		214-28-5760 84 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I MARYLAND WASHINGTON	Location BOONSBORO	T. 12, 1922	1ARYLAND 10d. Inside City Limits 1 ☐ Yes 2 ☑ No
:1215-0036 within 72 hours after death with the Maryland	ital Hygiene. od other then "naturel", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director		10f. Zip Code 21713 Nas Decedent of Hispanic Origin? (Specify Y f Yes, specify Cuban, Mexican, Puerto Rican		S.A. merican Indian,
15-0036	"naturel", or l	Completed by F	(Specify only highest grade completed) (Giv	1 ☐ Yes 2 ☒ No Specify: sedent's Usual Occupation re kind of work done during most of working . DO NOT use retired.	Specify:	WHITE ss/Industry
	tal Hygi d other event, I	To Be Comp	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) CLARENCE ERNEST IRVING	CORRECTIONAL OFFICER 18. Mother's Name (Firs	STATE st, Middle, Maiden Sumame) HERINE LANTZ	PRISON
S 8	27 is m r treum		19a. Informant's Name/Relationship (Type, Print) JANICE R. IRVING/spouse 20a. Method of Disposition 20b. Place of Disp	iling Address (Street and Number or Rural Rou 28 EL RANCHO ROAD, BOO position (Name of Date	ite Number, City or Town, State	AND 21713
Baltimore,	Department of Heal Importent: If item eny injury or othe		*4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	ANT FILMERAL HINGE	007 HAGERSTOW 6 Old National	N, MARYLAND Pike
PI	nysician (Medical		23a. Purt. Enter the disease or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		nsboro, Maryla Diratory arrest,	Approximate Interval Between Onset and Death
Ε	xaminer	ilcai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): APRIAL Fi Due to (or as a consequence of): APRIAL Fi Due to (or as a consequence of):	PATHY BRILLATION IN RE		6 mayle 4 Weeks 4 Weeks
Records, P.O. Box 68760, The law requires that the death certificate be executed	ned by the attending pl	Physician/Medical		l⊟Ectopic pregnancy □ Other (specify)	23d. Date of o	delivery Day Year
Records, P	been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the		:	Probably 4 Aunknown
		Be Completed	25. Was case referred to medical examiner?	1 26. Place of Death (Che	autopsy prior t death	
Division of or Attending Phys	death. stor: After this the funeral di	Certification: To	1 Yes 2 No Hospital: 11 Inpatient 2 ER/Outpatient 2 ER/Outpat	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No 28f. Lot street, factory, office 28f. Lot	5 ☐ Residence 6 ☐ Other (S _i) Describe how injury occurred ocation (Street and Number or Sity or Town, State)	
To the Hospitel	within 24 hours after To the Funerel Direc completely filled in by	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier	ath occurred at the time, date and place, and di investigation, in my opinion, death occurred at the 29c. License number	ue to the cause(s) and manner the time, date and place, and d	ue to the cause(s)
			30. Name and address of person who completed cause of death (Item 23a) (Type	D 46561	BOOMSBOR	4-25 2007
5/1	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	LAPPING KOAD	DUMBUK	0, 1116 01113
DHMH	17 Rev 1/2	001	ORIGIN	IAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2

			_ FOI	Certificate of Death	Reg. I	200/ 1101/
i	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
	/Medic		JOHN JETER		March 1	19,2007 12:27PM
)	Examin	er	4a. Facility Name (If not institution, give street and number) DOCTORS HOSPITAL	4b. City, Town, or Location of Death LANHAM		4c. County of Death PRINCE GEORGE'S
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir.	thday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	Birthplace (State or Foreign
	Director		250-34-3193 82	Yrs. Months Days Hours Min.		1925 SOUTH CAROLINA
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location		10d. Inside City Limits
	Maryl -f sho	tor	MD PRINCE GEORGE'S CAP	PITAL HEIGHTS		1 X Yes 2 □ No
	or 28a	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	23a c	ral	5105 ADDISON ROAD	20743		U.S.A.
	er dea items ner m	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☒ Married 1 □ Yes 2 ☒ No	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	 Race - American Indian, Black, White, etc.
36	hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No Specify:		Specify: BLACK
15-0036	d within 72 hours after death with the Marylar piene. r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work	ing 16b	. Kind of Business/Industry
N	be filed within 72 ital Hygiene. d other than "nai event, the Medical"	mple	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	9	DOTTIAME
d 21	it it ji	ပ္ပ	9th 17. Father's Name (First, Middle, Last)	AMTRAK FORMAN 18. Mother's Name	e (First, Middle, Maid	PRIVATE den Surname)
Maryland	should be filed and Mental Hyg s marked other umatic event, i	To Be	ELIOUSE JETER SR.	CARIE	ROBINSON	
ary	2 shou and N is mai	-		. Mailing Address (Street and Number or Rur	al Route Number, Cit	ty or Town, State, Zip Code)
	5 4 7 F		· · · · · · · · · · · · · · · · · · ·	105 ADDISON ROAD CAP		
or e	Pages 1 ar		I Z Bunai 2 Li Cremation 3 Li Hemovai nom State	ry, crematory or other place)		Location - City or Town, State
Baltimore,			4 □ Donation 5 □ Other (Specify) FT . LI 21. Signature of Funeral Service Licensee			RENTWOOD, MARYLAND
Ba	permit. Departi Importi any inj	8 1	X. N. M-hall	7474 LANDOVER ROAD		
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	n Cardian &	Seath	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence	n Cardiac &		hrs
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	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Acuse-		
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68760,	rtificate be executed ng physician and as the burial-transit	Nedical	d			
Box	nding puse as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy	_		23d. Date of delivery
	at the death cert by the attending stached for use a	Physician/	in the past 12 months? 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
O.	at the by the stache	Phys	9 Unknown		1	
g,	The law requires that the ate has been signed by the bage 2 should be detache	by	O a 17 Dec De a	n the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Š	w requires been signe should be	eted	Sal source C	6000		
Records,	sician: The law certificate has l irector, page 2 s	Completed	- Jeffers		24a. Was an autopsy performed	
Vital		ø	25. Was case referred to medical	26. Place of Deat	1 Yes 2 ☐ h (Check only one)	No 1 □ Yes 2√€ No
	Sir d	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/OL	utpatient 3 DOA Other: 4 Nursing Ho	ome 5 Residence	e 6 □Other (Specify)
Division or	ing Pl		1 Natural 5 Pending (Month, Day Year)	Time of 28c. Injury at Work?	28d. Describe how i	njury occurred
ISIC	death ctor: y the f	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, fa	M 1 ☐ Yes 2 ☐ No	28f. Location (Stree	t and Number or Rural Route Number,
2	ai or / s all er il bire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, S	tate)
	lospit hour unera		29a. Certifier (Check only (C	e, death occurred at the time, date and place,	and due to the caus	e(s) and manner as stated.
	To the Hospital or Attending Pl within 24 hours a ler death. To the Funeral Circetor: A ler th completely filled in by the funera	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
ì	iv 7 8		Solver and the order times	D14876	,	
\	(12)	l 8	30. Name and address of person why completed cause of death (Item 23a)			3.19.07
<u>را</u>	(0)	d b	SURESH C. GUPTA M.D. 4701 RANDOL	PH ROAD ROCKVILLE, MA	RYLAND 208	352
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature 1	Le la		

		For State Registrar		State of	Marylar		ertificate of F			iene (2007		0 8
		Negistrar Decedent's Nam	ne (First, Middle,	Last)					2. Date of Dear	th		3. Time of	Death
Physicia /Medic		Don	ald	Fredolph	ı Jo	ohnso	n		Month March	21 Day	2007	4:55	A M
Examine				give street and numl			1	r Location of Death		4c. Co	ounty of Death)	
	и	Riderwood	d Villag	ge Assiste	d Liv	ing	Silver			Mo	ntgome	ry	
Funeral		5. Social Security N	Number 6	3. Sex 7 11☑ M 2 ☐ F	. Age (In yrs.	last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	, Year)	Cou	place (State or intry)	r Foreign
Director		475-01-5 Usual Residence of		'A'''	88	Yrs.			Dec 12	, 191	8 Min	nesota	
land t t		10a. State	10b. County		10c. Ci	ty, Town or L	ocation					10d. Inside Cit	y Limits
Mary f sho	ō	MD	Montgom	10757			Silver	Spring				1 □Yes	2 No
r 28a	Director	10e. Street and Nu		ier y			10f. Zip Code	Spring	1	0g. Citize	n of What Cou	untry?	
h with		3160 Gra	acefield	Road, Ur	i+ 110	03	2090	Δ			USA		
deat ems	Funeral	11. Marital Status	40011010	12. Was Deced	ent Ever in L	J.S. 13	. Was Decedent of H		ecify Yes or No-		. Race - Amer Black, White		
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e filec al Hyg othe vent,	BeC	17. Father's Name	(First, Middle, La	ast)				18. Mother's Name	e (First, Middle, I	Maiden Su	urname)		
Menta	70	Daniel	Fredolp	oh Johns	on			Helma	Marie	M	Midthun		
2 shc and is ma		19a. Informant's N	lame/Relationship	(Type. Print)		19b. Mai	ling Address (Street	and Number or Rur	al Route Number	r, City or T	Fown, State, Zi	ip Code)	
and lealth m 27 her tr				, daughte			Box 280	·					
it of H		20a. Method of Disp 1 ☐ Burial 2	Cremation 3	B □Removal from Si	ate	cemetery, cri	oosition (Name of ematory or other place	ce)			ation - City or T	,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	-	4 ☐ Donation 21. Signature of Fu	25 ☐ Other (Spe		Me		Litan Crem 22. Name and Addre				andria,		
Depar Impo any Ir		▶ W D	A Service Li	R. Cul			8325 Mt.	Na	usch Fur				
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tendii eath. tor: A the fu	catic	2 Accident	investigat	the			M 1 🗆	Yes 2□No					
or At after d Direct in by	Certification:	4 ☐ Hornicide	determine	ed 28e. Place o	f injury - At h g, etc. <i>(Sp</i> ec		treet, factory, office		28f. Location (S: City or Town		Number or Ru	ral Route Numi	ber,
spital ours a neral filled		29a. Certifier	1 X Certifying	Physician: To the b	est of my kn	owledge, dea	ath occurred at the tir	me, date and place,	and due to the c	ause(s) a	nd manner as	stated.	
To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	(Check only one)	2 ☐ Medical Ex	xaminer: On the bas	sis of examin	ation and/or	investigation, in my o	opinion, death occur	red at the time, o	late and p	lace, and due	to the cause(s)
To t	Ž	29b. Signature and	title of certifier	1/			29c. Licens	e number	2	9d. Date	signed (Month	, Day, Year)	
		160	DV	red 1	no		D 345	90		03–21	1-07		
5+1				ho completed cause				Trom Consider	or MD 2	0004			
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Registra			MAR	2 3 2007	Barrer	w St.	April 1						
MH 17 Bev 1/20	01						1						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** William Rutherford Kreitzer March 25, 2007 7:40 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 23633 Town Creek Drive Lexington Park St. Mary's If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 XM 2 □ F Director 260-60-1339 88 10/25/1918 Georgia Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show must be notified at 1 ☐ Yes 2 X No Director Lexington Park Maryland St. Mary's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a or United States 23633 Town Creek Drive 20653 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married P 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ Specify: 3 Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the United States Navy Pilot Department of Health and Mental Hygis Important: If Item 27 is marked other any Injury or other traumatic event, tt once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 William Clausen Kreitzer Elizabeth Rutherford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Kreitzer/Daughter 2410 Wildflower Lane, Huntingtown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 05/30/2007 Arlington, Virginia Arlington National 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. 20650 M00052 22955 Hollywood Road, Leonardtown, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner executed as the burial-tran a Exection Fraction = 30% Division or Vital Records, P.O. Box 68760 or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1□ Yes 2□No Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Mann of Death 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? After 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours at To the Funeral Completely filled is 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) MO 30. Name and address of person who complete e of death (Item 23a) (Type, Print) Szkotnicki 22576 MacArthur Boulevard, California, MD <u>Michael</u> S. M.D. 31. Date filed (Month, Day, State MAR 28 Registrar

Stluis-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Marylar 1 - State Amended 31,3/27/07,LDB,DOF		rtment of H			0.0	A =	11000
	4.		1. Decedent's Name (First, Middle, Last)	Cer	illicate of t	Jeani	2. Date of Dea	eg. No.	11/	3. Time of Death
	Physicia		Elnœra Laura Knauer				March :	23, 200	Year 7	4:35 PM
ŀ	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	1	4c. County		
3			3265 Knauer Road		Cambri	_	T = == =		heste	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 1 □ M 2 ☒ F 98	"	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Year) 1909	Counti	ace (State or Foreign ry) yland
	D		Usual Residence of Decedent				11 CD. 11	1505		
	arylar show d at	'n		ty, Town or Loc					10	d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M 28a-f notifie	ecto	MD Dorchester 10e. Street and Number	Cambri	10f. Zip Code			I0g. Citizen of W	Vhat Count	
7	3a or	io I	3265 Knauer Road		21613			USA		•
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alla	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inpartment of Health and Mental Hygiene. The mortifier of 15 marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at once.	Be	17. Father's Name (<i>First, Middle, Last</i>) Benjamin Franklin McWilliams			18. Mother's Nam		maiden Surnam rington		
ary	shoul and Me s mark	₽	19a. Informant's Name/Relationship (Type. Print)	1	g Address (Street					Code)
Ξ,	and 2 ealth a m 27 is		Irvin C. Knauer, Jr. Son		Windy Hil					
lore	Pages 1 nent of H ant: if ite ury or oth		Laburiar 2 Deferration 3 Deferroval from State		sition (Name of natory or other plac		Date	20c. Location -	•	
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_	Physician: this certific ral director,	To B	A STATE OF	ER/Outpatien		4 □ Nursing H	ome 5 Resid	lence 6 🗆 Oth	er (Specify)
0 0	ing P After t unera		27. Manner of ath 1	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe h	ow injury occurr	red	
ISION	Attending r death. ector: Afte	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury. At the control of the country of the countr	iome, farm, str		162 Z [NO	28f. Location (S	Street and Numb	er or Rural	Route Number,
2	s after al Dire	Certification:	4 ☐ Homicide determined building, etc. (Spec	(fy)			City or Tow	n, State)		
	To the Hospital or Attending Physician: The I within 24 brours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical (29a. Certifier (Check only 2 ☐ Medical Examiner: On the basis of examin							
	To the within 2 To the comple	Med	one) and manner stated. 29b. Signature and title of certifier.		29c. Licens	e number		29d. Date signe	d (Month, L	Day, Year)
	-5-0		Marillan War	115	DE	31766		7-2	6-07	7
			30. Name and address of person who completed cause of death (Ite		Print)					
			Mary And D. Moore, M.D.		orcheste		1.74 m. 7 m. 1	-		
	Sta Registr		31. Date filed (Month Day Year) 32. Registrar's Sign	D. A	marks	MAR 26	2007	Mar.	to ,	God

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Decedent's Name (First, Middle, Last)

5. Social Security Number

578-22-4761

Maryland

11. Marital Status

10e. Street and Number

Usual Residence of Decedent

Mildred Virginia Lilly

6105 Longfellow Street

10b. County

6105 Longfellow Street

15. Decedent's Education (Specify only highest grade completed)

1 Never Married 2 Married

3 Nidowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

11

4a. Facility Name (If not institution, give street and number)

1 □ M 2 🛛 F

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

College (1-4or 5+)

Prince George's

Baltimore, Maryland 21215-0036 Be ۵ Welby Gray Ruth Starkey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hubert Lilly - Son 6105 Longfellow St., Riverdale, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Resthaven Memorial Gardens 3/23/2007 4 □ Donation 5 □ Other (Specify) Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsion Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Malnut Due to (or as a consequence of) signed by the attending physician d be detached for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed: 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MEMRU MASTER, MIN 3/19/07 D050514 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) suite 2100 MASTER, Mp. 6570 Kenilventh are Rinerelale Mrs, 20737 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 2 2007 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City. Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min.

20737

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify

(Give kind of work done during most of working life. DO NOT use retired)

Riverdale

Days

Months

10f. Zip Code

1 ☐ Yes 2 ☑ No

16a. Decedent's Usual Occupation

Homemaker

7. Age (In yrs. last birthday) 83 Yrs.

10c. City, Town or Location

Riverdale

2. Date of Death

18

8. Date of Birth (Month, Day, Year

Aug 10,

18. Mother's Name (First, Middle, Maiden Surname)

2007

4c. County of Death

10g. Citizen of What Country?

USA

16b. Kind of Business/Industry

Own Home

Prince George's

14. Race - American Indian,

White

Virginia

8:50 A

10d. Inside City Limits

1X Yes 2 No

Birthplace (State or Foreign Country)

Month

Mar.

			State Registrar	State of Marylan	•	artment of H tificate of L			giene	007)22	
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath Day	Year	3. Time of		
	/Medic		WILLIE ERWIN LYNN				. 100 100 100	03-15-			1320	М	
	Examin	er	4a. Facility Name (If not institution, give si PRINCE GEORGES HOS			4b. City, Town, or		Death		ounty of Death	00000		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	CHEVERL If Under 1 Year	If Under 24		h	INCE GE	place (State o	or Foreign	
ш	Director		244-84-7444	M 2□F 58	Yrs.	Months Days	Hours	,	Day, Year) Country) NORTH CAROLINA				
	p .		Usual Residence of Decedent 10a. State 10b. County	100 Cin	, Town or Lo	cotion					10d. Inside Ci		
	h the Marylan r 28s-f ehow	5	MD PRINCE GEO	1	TOL H					'	1 Ty Yes	-	
	288-1	Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cour	ntry?		
	3a or		111 SULTAN AVENUE			20743			USA				
	deet deet	Funeral	11. Marital Status	Was Decedent Ever in U. Armed Forces?	S. 13. \		spanic Origin	? (Specify Yes or No Puerto Rican, etc.)		I. Race - Americ Black, White,			
9	hours after deeth with the Maryland tural; or items 23a or 28s-f show al Exercine crount be notified at		1 Never Married 2 Married	1 ☐ Yes 2 【XNo If Yes, Give		1 ☐ Yes 2 ဩ No	Specity:			Specify: BLA			
5-0036	hours tural	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a Decer	ient's Usual Occupa	ation			d of Business/In			
215	within 72 ene. than "na! he Medic	piet	(Specify only highest grade	completed)	(Give	kind of work done of DO NOT use retired	luring most of	f working		RITY KN	-		
212	d with giene	Completed	Elementary/Secondary (0-12) 12TH	College (1-4or 5+)	SECUE	RITY OFFI	CER			ECTIVE :		E	
	be filed tal Hygi d other avent, I	Be (17. Father's Name (First, Middle, Last)					Name (First, Middle,		'umame)			
Maryland	should I nd Meni marke	၉	JUNE LYNN					FRANCES RO					
Mar	ha 7		19a. Informant's Name/Relationship (Typ	e, Print)				o <i>r Rural Route Numbe</i> ITOL HEIGH					
	f Healt f Healt item 2 other		MAXINE LYNN/WIFE 20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of		Date		ation - City or To			
ē	8°= 5		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		natory`or other plac EMORIAL P		3-24-07	мттн	FIELD, 1	N C		
<u>a</u>	permit. Pa Depertmen important: any injury.	ı	21. Signature of Funeral Service License					MARSHALL'S					
<u>m</u>	8818		Julia V-1	1 ouska	43	308 SUITL	AND RD	., SUITLAN	D, MI	20746			
Ę			23a. Part Enter the disease, or complice shock, or heart failure. List only on	eations that caused the death e cause on each line.	. Do not ent	er the mode of dying	g, such as ca	rdíac or resoratory	yest,	~	Approximate Interval Bet Onset and I	ween	
	Physician		tmm late Cause (Finaf disease or condition resulting in death)	H ypo	the	· En	en	holog	ac		Onosi uno		
	/Medical Examiner		Tooland in county	Due to lows a consequence	nce of):	27		1)			
		ē	Sequentially list conditions, if any leading to immediate	Lue to jor as a conse,	uence on:	1		anse	20				
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Huss	nd	no	Los	$\overline{}$					
oʻ	s be executed sicien and burial-transit		resulting in death) Last	Due to (or as a consequence	uence of):	1							
8760	# × #	dical	d	mar	ece	<u>ے</u>							
9 X	leath certifica attending ph I for use as th	Physician/Me	IF FEMALE: 23	3c. If yes, outcome of pregna	ncy				23	3d. Date of delive	erv		
Вох	atter for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of di		Ectopic pregnancy Other (specify)				Month		Year	
J.	of the de by the a	hys	9 Unknown	9□ Unknown									
	as the gned be de	by F	Part fl. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	100	· ·	e contribute to t			
ecords,	w requir been si should I	eted						_ 10			bably 4 □l		
Rec	hysician: The law his certificate has t I director, page 2 s	Completed						24a. Was autop		24b. Were auto prior to co death?	opsy findings ompletion of c	available ause of	
	n: The ficate ha	မ ငိ	25. Was wase referred to medical				00.01	1 ☐ Yes	No	1 ☐ Yes	2□ No		
Vital	/sicia s cert	To Be	examiner?	ospital: 1 Inpatient 2	ER/Outpatier	nt 3□DOA Othe	200	f Death (Check only of ing Home 5 ☐ Resi		□Other (Specia	fv)		
פֿ	Attending Physician: r death. sctor: Atter this certific by the funeral director,		27. Many er of Death	28a. Dale of Injury (Month, Day Year)	28b. Time of			28d. Describe			<i>y</i> ,		
Sio	tendin Jeath. tor: Af the fur	atic	1 Stural 5 Pending investigation	(, 22)	,		Yes 2 □No						
Division of		Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str //	reet, factory, office		28f. Location (City or To		Number or Run	al Route Num	ıber,	
_	Hospitai 14 hours e Funeral [29a, Certifier 1M Certifying Phys	ician: To the best of my kno	wledne deat	h occurred at the tire	ne date and r	place, and due to the	cause(s) a	and manner as s	stated.		
		Medicai		er: On the basis of examina and manner stated.								5)	
	To the within 2 To the complet	Me	29b. Signature and little of certifier			29c. License	e number		29d. Date	signed (Month,	Day, Year)		
0			1 Will	re		Di	23/	8	3/	15/0	27		
12	- (10)		10000	'enis 3001	HOSF	Print) Dr	ive C	Hererly	MD	2078	5		
	Sta Registi		MAR 23 2007	32. Registrar's Signa	TUTO TUTO			•					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** L. Mary Lynch Mar. 20, 2007 11:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7005 Wells Parkway Hyattsville Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Yrs 172-26-2638 84 Director June 18. France Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, fnside City Limits 28a-f ehow the Medical Examiner must be notified at X Yes 2 No Directo Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or Items 23a 7005 Wells Parkway deeth 20782 **USA** Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White δ 3 ⊠ Widowed 4 □ Divorced 'natural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Comple Elementary/Secondary (0-12) College (1-4or 5+) 2+ Il Hygiene. Homemaker Own Home permit. Pages 1 and 2 should be file Deportment of Health and Mental Hy Important: if Item 27 is marked oth any linyry or other traumatic event gote. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Leon Bourgeois Unknown 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Lasick Balloch-Daughter 7005 Wells Parkway, Hyattsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ⊠ Burial /2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation /5 ☐ Other (Specify) / 3/26/2007 Burlington New Jersey Beverly Cemetery 22. Name and Address of Facility 4739 Baltimore Avenue 21. Signature of Juneral Service Licensee Must Gasch's Funeral Home, P.A. Hyattsville, MD 20781 os that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. 23a. Part 1 Enter the disease, or complicate shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in death) Pancreas cancer **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 2 Deetal death ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. δ 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No Be 25. Was case referred to medical 26. Pface of Death (Check only one) examiner Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Tes 2 No 28a. Date of fnjury (Month, Day Year) 28c. fnjury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Naturaf 5 Pending s after de... 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number rus allet D23743 3/21/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Weltz, MD 7525 Greenway Center Dr, Greenbelt, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 23 2007 Registrar

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year

MAR 23 2007

32. Registrar's Signat

10

State Registrar

DHMH 17 Rev 1/2001

300 West Ninth Street, Frederick, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD,

MAR 2 6 20107 >

32. Register's Signature

Ali J. Afrrokteh,

31. Date filed (Month, Day, Year)

			1- For State of Maryland / Departs Registrar Certification	ment of Healt			ene 2007	11027
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Paul Leroy Long			2. Date of Death Month March 2	26 ^{Day} 2007	3. Time of Death 4:30 A M
	Examin		4a. Facility Name (If not institution, give street and number) Charlotte Hall Veterans Home	b. City, Town, or Local Charlotte			4c. County of Death	
	Funeral Director				nder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, June 4,	Year Co	nplace (State or Foreign untry) y land
	aryland show	'n	Usual Residence of Decedent 10a. State 10b. County Maryland St. Mary's	ion Charlotte l	Ha11			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	death with the Maryland ms 23a or 28a-f show	Funeral Director	10e. Street and Number 29449 Charlotte Hall Road	10f. Zip Code 206	622	10	g. Citizen of What Co USA	untry?
	be filed within 72 hours after death with the Marylan Hygiene. d other then "natural", or items 23s or 28s-f show avant, the Medical Examinar must be notified at	by Funera	1 ☐ Never Married 2 ☐ Married 1 1 1 1 1 No	s Decedent of Hispanies, specify Cuban, Me	ic Origin? (Spe exican, Puerto I ecify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	
21215-0036	I within 72 horiene. r than "naturaline in Medical i	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	it's Usual Occupation ad of work done during NOT use retired) Ouse Worke			U.S. Gover	
yland		To Be C	17. Father's Name (First, Middle, Last) James Robert Long	18. N			_{laiden Sumame)} ude Cusick	
, mary	s 1 and 2 should t Health and Mer Itam 27 le marke other traumatic		19a. Informant's Name/Relationship (<i>Type, Print</i>) Thomas Roderick Long / Brother 19b. Mailing A 26972	Address (Street and N Cat Creek	lumber or Rura Road M	^{/ Route Number,} lechanic	City or Town, State, 2 sville, MD	Zip Code) 20659
Saltimore	Pages 1 ament of He ment of He ant: If Itan ury or oth		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition cemetery, cremate Charles Memo	lory or other place)	March	29.	eonardtown,	
Balt	Departi Departi Importa any Inji once.		M. M. M. M. M.	lame and Address of F lattingley-Ga 2.0. Box 270	rdiner F	uneral Hom town, MD 2	ne, P.A. 20650	
	Physician		23a. Part. Enter the disease, of complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	he mode of dying, suc LTERY	ch as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	TRUCTIVE	ELU	NE DI	<i>FASE</i>	
/60,	ate be executed hysician and he burial-transit	cal Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	MELLIS	TUS			
20 X 68	ath certifica attending pl	Physician/Medic	in the past 12 months?	ctopic pregnancy			23d. Date of del Month	ivery Day Year
О.	0 0 0	by Physi	9 Unknown Part II. Other significent conditions contributing to death but not resulting in the unde		Part I.	23e. Did tob	ecco use contribute to	the cause of death?
Hecords,	law requires that the as been signed by th 2 should be detache	Completed b				1 Ye	24b. Were au	obably 4 Unknown
Vital Ke	The ate h page	0	25. Was case referred to medical	26	Place of Death	autops perform 1 Yes 2	ned? death? !DNo 1 ☐ Yes	compfetion of cause of
Division of V		tlon; To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation Hospital: 1 Inpatient 2 ER/Outpatient 28b. Time of Injury	100	Nursing Hor	me 5 ☐ Reside	nce 6 □Other (Spe	cify)
DIVISI	in Title	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	I, factory, office	:	28f. Location (St. City or Town	reet and Number or Ri , State)	ural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge death of the pass of examination and/or invessed and manner stated.	onumed at the time, destigation, in my opinion	ata and plana a n, death occurr	and due to the ca ed at the time, da	ate and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License num	7.90k	2!	9d. Date signed (Mont	/
			30. Name and address of poson with a pleted cause of death (ftem 23a) (Type, Print 12070 Old Line Centre Waldorf, MD 20602	int) Louis V.	Kaufman	, M.D.	(-/	
6	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature			-		

01 02241	Please Type of Pfillt in black indelible link. Elisate All Copies All
Carolyn P. Lundmark	State of Maryland / Department of Health and Mental Hygien
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		I- For State Registrar		,	Certific	ate of	Death			Reg	J. N o.		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Physici	an/ Î	Decedent's Name (First, Midd	le,Last)							ite of Death	Day	Year	3. Time of Death
Medical Exami		Carolyn Patri	cia Lu	ındmark					Ma	rch 23, 2	2007		1355 hrs
		4a. Facility Name (if not institution		et and number)		4	b. City, Town, or Prince Fred		eath		Calv	unty of Death	1
4		Calvert Memorial Hos		17.4	// (411			Uro Io r	ato of Birth			thplace (State or
Funeral Director		5. Social Security Number 214–02–6775	6. Sex	_	(In yrs. last bir	tnday) Yrs.	If Under 1 Year Months Day		A.d. or	7/11/		Foreig	yiland
ý	Į	Usual Residence of Decedent 10a. State 10b. County			10c. City, Towr	or Locati	00						10d Inside City Limits
w any	1	10a. State 10b. County					OH						1 Yes 2 No
daryland 28a-f show 1 at once.	ģ	Maryland Calv	ert		Solo	mons	10f. Zip Code			110	Citizon	of What Cou	
Mary r 28a ed at	Director	10e. Street and Number	-1							,	-	d Stat	•
th the Maryland 23a or 28a-f sho notified at once.		14324 Calvert				T	20688			Specify Yes or No- 14. Race - American Indian, Bla			
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shr matic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 M	larried 1		XNo	If Y	es, specify Cuba	n, Mexican, Pu				White, etc.	white
s after ral",	百		orced If Yes, or Da	tes:	-1-1-15 140-		Yes 2 X No		l of work d	200		cify: of Business/	Industry
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5-0036 iled within 7 Hygiene.	Ę.	12 17. Father's Name (First, Middle	Last)					18 Mother's N	ame (First	, Middle, Mi			
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A Donation 5 Other Specify: 21. Signature of Funeral Service Licensee P.O. Box 600 Lusby MD 20									ı ione				
Physician	Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or							or heart	Approximate Interval Between Onset and				
/Medical		failure. List only one cause Immediate Cause (Final disease		e. cute reac	tive air	wav di	sease						Death
Examiner		or condition resulting in death)		o (or as a conse									
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cox 68° eath certiff attending for use as	lä	past 12 months?	14	Live birth Pregnant at	time of death		tal death sher (Specify)	Ectopic pie	egnancy		""	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	buy , su.
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f Vil Physic er this	ြို	1 ✓ Yes 2 No 27. Manner of Death	12			. Time of		ury at Work?		Describe h			
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Nestigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number of the control of t								Number or R	tural Route Number, City				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1													
Spits bours mera		4 Homicide	1		u kasudadaa s	loath occu	irred at the time,	date and place	and due	to the cause	e(s) and n	nanner as sta	ated.
Division of Vital Records, P.O. Box 68760, within 24 brows after the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 brows after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only certifying in one) 2 Medical Ex	aminer: On t	he basis of exa	mination and/o	r investiga	ation, in my opinio	on, death occur	red at the	time, date a	and place	and due to t	the cause(s)
To To con	Med	29b. Signature and title of certif		manner stated			29c. Licer	nse number			29d. Dat	e signed (M	onth, Day, Year)
		(Tand	D X	HAD 1) a .		0.0	M.E.			March	24, 2007	
_		30. Name and address of person	on who comp	leted cause of	death (Item 23a)			-				
		Carol Allan, MD A	ssistant N	fedical Exa			Street, Baltir	more, MD 2	1201				
	tate	8/11/12/5/11/11/11	7 4	32. Registra	ar's Signature	10 8 s							
Regi	strar	MAR 3 0 200	fred.	COST!	A STATE OF THE PARTY OF THE PAR	The state of the s							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** ам Thi Luu March 22, 2007 3:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🕱 F Director 212-29-6715 75 May 5, 1931 Vietnam Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Montgomery <u>Rockville</u> 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or 14109 Chelmsford Road 20853 Vietnam by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Asian Specify: 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) 9 Homemaker Own Home event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ages 1 and 2 should be fill sent of Health and Mental H it: If Item 27 is marked oth y or other traumatic evening the second of Be 2 Nam Luu Bay Thi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andy Du/Son 4512 Bestor Road, Rockville, Maryland 20853 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages ment of h 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State March 26, Department or important: If any injury or Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) d 2007 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrest 10 Minutes /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed burial-trar Due to (or as a consequence of): physician Physician/Medical death certificate the as attending r IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be Completed by Pneumonia, Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy cate ha perform 2 □No 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 🖪 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 F Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760. o <u>م</u> or Vital Records, Division

death.

To the Hospital or Attending within 24 hours frer deal To the Funeral Director completely filled in by the

2

29a. Certifier (Check only one)	1 Certifying Physician: To the best of my knowledge, death occ 2 Medical Examiner: On the basis of examination and/or investiand manner stated.		
29b. Signature and	title of certifier A.M.	29c. License number D58681	29d. Date signed (Month, Day, Year) March 22, 2007

Jude Alexander, M.D. 31. Date tiled Montal R

determined

30. Name and a 37 s of person w o completed cases of death (It in 23a) (Type, Print)

2007

4 ☐ Homicide

9901 Medical Center Drive, Rockville, MD 20850

State Registrar

Medical 29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. (2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Richard Vincent Landis 12:02 A^{M} 21 2007 March 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 10, 1926 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Pennsylvania 171-20-5261 80 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2√XNo Anne Arundel Maryland Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2113 United States Unit 102 2412 Chestnut Terrace 12. Was Decedent Ever in U.S. Armed Forces? ₩XYes 2 □ No if Yes, Give Year or Dates: ₩WII 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married XX Married 1 ☐ Yes ŽXNo White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Episcopal Minister Ministry 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elise Goss Richard G. Landis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2412 Chestnut Terrace Unit 102 Odenton, MD 21113 Alice L. Landis / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2XXXCremation 3 ☐ Removal from State 3/22/2007 Baltimore Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licensee Micha Annapolis,MD 21401 147 Duke of Gloucester St. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DCAMINIZ disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 KIER/Outpatient 3 □ DOA 28d. Describe how injury occurred

Physician /Medical Examiner

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within 24 hours after death To the Funeral Director: completely filled in by the

or Attending

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Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

Physician

/Medical

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Medical Certification: To

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Maryland 21215-0036

Baltimore,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1 ☐ Yes 2 ☐ No

27. Manner of Dea h 1 Natural

29b. Signature and title of certifier

5 Pending investigation 2 Accident 3 Suicide 4 Homicide

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

(0 one Ur.

29a. Certifier (Check only one)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who inpleted cause of ceath (Item 23a) (Type, Print)

on Day, Year

TIDEWATER Registrar's Signature

State Registrar

			For State	State of M		partment of Fertificate of	Health and Ma Death	-	giene Reg. No. 200	7 11001				
			Registrar 1. Decedent's Name (First, Middl	e. Last)				2 Date of De	ath	3. Time of Death				
п	Physici	an	Juanita Mc					March	Day 200	7 4:00 AM				
1	/Medic		4a. Facility Name (If not institution			4b. City. Town, o	or Location of Death	Tricero	4c. County of Dea	, , , , , , , , , , , , , , , , , , , ,				
1	Examin	er				_	_							
			5. Social Security Number	Community Ho	SPITAL je (In yrs. last birthda		anham If Under 24 Hrs.	8. Date of Birt	h 9. Bir	George's				
	Funeral Director		1	1 □ M 2 □XF	Yrs.	Months Days	Hours Min.	(Month, Da		ountry)				
			248-66-8885 Usual Residence of Decedent		69			Dec. 25	, 1937 1500	th Carolina				
/	laryland show ed at		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits				
	Man -f sh	ţ	DC				Washingt	on		1 X Yes 2 No				
	r 28a	Director	10e. Street and Number			10f. Zip Code	Washinge		10g. Citizen of What C	ountry?				
	3a ol		508	M St., NE #	1		20002		United	States				
	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Funeral	11, Marital Status	12. Was Decedent		3. Was Decedent of F	Hispanic Origin? (Spe ean, Mexican, Puerto I	cify Yes or No		erican Indian,				
"	r iter	Fur	1 □ Never Married 2 □ Mar	Armed Forces?				Hican, etc.)						
38	al",o	þ	3 Widowed 4 Divorced	I If Yes, Give ""		1 ☐ Yes 2 ☑ No	Specify:		Specify:	Black				
21215-0036	2 hou	Completed		t's Education	16a. De	cedent's Usual Occup	pation		16b. Kind of Business	s/Industry				
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21,	r the	Į,	11th		- '	Charf	orce		Gov	ernment				
b	othe	Be	17. Father's Name (First, Middle,	Last)			18. Mother's Name	(First, Middle,	Maiden Surname)					
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Σ	shou nd M mar	-	19a. Informant's Name/Relations	ship (Type. Print)	19b. Ma	ailing Address (Street	and Number or Rura	l Route Numb	er, City or Town, State,	Zip Code)				
Ĭ	nd 2 Ilth a 27 is rtrat		Sherry Claws	on/Daughter		508 M St	., NE #1	Wash.	DC 20002					
ā,	ges 1 and 2 should be filed within 72 hours after death with the Maryle it of Health and Mental Hyglene. If Item 27 is marked other than "natural", or items 23a or 28a-f shoot other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition		20b. Place of Dis	nosition (Name of	; D	ate	20c. Location - City o					
Baltimore,	Pages nent of H int: if ite		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5			rematory or ones pla		10007	CI.	00				
Ħ	permit. Pages 1 and Department of Health Important: if Item 27 any injury or other tr once.		21. Sign ture of Funeral Service		Rehobot	h A.M.E. 2 22. Name and Addre	4 em 116	/2007	Cheste					
Ba	permit. Page Department of Important: If any injury or once,		21. Signature of Furieral dervice	5/2 00 1					Funeral Ho					
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			shock, or heart failure. Lis	3a. Part Finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
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	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):									
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9	leath certifica attending pt I for use as tl	Mec	IF FEMALE:											
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	requires that the death certific een signed by the attending p nould be detached for use as	by F	Part II. Other significant condit	ions contributing to death	but not resulting in the	e underlying cause gi	ven in Part I.	23e. Did 1	obacco use contribute	to the cause of death?				
Records,	w require been signature	ba						10	Yes 2√∏No 3⊡I	Probably 4 ☐Unknown				
ပ္ထ	> D 0	Completed						24a. Was		autopsy findings available				
Ä	The la	E						auto perfo	ormed? death?	o completion of cause of ? es 2 □ No				
tal	ifficat	Ö	25. Was case referred to medica	al 1			26. Place of Death			55 2 10				
>	Physician: this certific	00	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ient 2 ∏ ER/Outpa	tient 3 DOA Ot	hor:		dence 6 □Other (Sp	necifu)				
Division or Vital	Phy rrthis gral d	5. 7.	27. Manner of Death	28a. Date of Inj	ury 28b. Tim				how injury occurred	, cony)				
on	Attending r death. ector: After	ë	1 Natural 5 Pendi	ng (Month, D	a <i>y Year)</i> Inju		ork?]Yes 2∐No							
S	deat ctor: y the	Sa	3 Suicide 6 Could		ijury - At home, farm,	street, factory, office		28f. Location (Street and Number or i	Rural Route Number,				
<u>S</u>	or A after Dire	Certification:	4 Homicide determ	nined building,	itc. (Specify)			City or To	wn, State)					
	the Hospital nin 24 hours a the Funeral I		29a. Certifier 1 K Certify	ng Physician: To the bes	t of my knowledge, d	eath occurred at the	time, date and place.	and due to the	cause(s) and manner	as stated.				
	Hos 24 hc Fun Fun	lica	(Check only 2 Medica	Examiner: On the basis	of examination and/o	r investigation, in my	opinion, death occur	red at the time	, date and place, and d	ue to the cause(s)				
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29b. Signature and tipe of certifi	- (-) 		29c. Licen	se number		29d. Date signed (Mo	nth, Day, Year)				
	To To		W	h.M. Ni	1M P									
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0	(2)		30. Name and address of person	1			- D C	1 . 1 .	MD 00770					
1				Gaskins, M.I	rada Cianaturos		t Dr., Gre	enbelt.	, MD 20770					
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			1 - For State Registrar	State	of Maryla		rtment of H	lealth and N <i>Death</i>		giene		1032
			Decedent's Name (First, Mid	dle, Last)					2. Date of Dea	ath		3. Time of Death
	Physicia	_	Emma	Louise	Mack				March	Day 6	Year 2007	7:44p M
	/Medic Examin		4a. Facility Name (If not instituti				4b. City, Town, o	r Location of Death			inty of Death	7.44p
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-	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. (ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birthp	place (State or Foreign
	Director		250-32-4940	1□M 2 F		83 Yrs.	Months Days	Hours Min.	(Month, Da)	1923	South	h Carolina
			Usual Residence of Decedent									ouroring
	ylan		10a. State 10b. Coun	ty	10c. C	City, Town or Lo	cation				1	10d. Inside City Limits
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	r 28	ie	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cour	ntry?
	h wit	<u>=</u>	2025-A 38t1	h St. SE			20002			USA		
	deat	Funeral	11. Marital Status	12. Was De Armed F	cedent Ever in	U.S. 13. V	Vas Decedent of H	lispanic Origin? (Sc an, Mexican, Puerto	pecify Yes or No-	14. [Race - Americ	
0	after or Its	교	1 Never Married 2 M	arried 1 ☐ Yes	2 XNo				riican, etc.)			
3	all, o	b	3 ☐ Widowed 4 ☐ Divorce	ed If Yes, G			☐ Yes 2X No	Specify:		Spe	ecify: Bla	ack
5	72 h	Completed		ent's Education nest grade completed	()	(Give	lent's Usual Occup	during most of world	kina	16b. Kind o	of Business/In	dustry
-	the state of	ple	Elementary/Secondary (0-12		(1-4or 5+)	life. L	OO NOT use retired	d)	9			
4	gien a	Š	12	2		Tea	cher			DCPS	Govern	nment
2	e file	Be (17. Father's Name (First, Middle	e, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Sun	name)	
<u> </u>	Aent Aent rked rice	To	Leander 1	Mack				Jessie	2			unk.
<u></u>	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Iteme 23a or 28a-f show reumatic event, the Maclical Exarcher must be notilised at	ľ	19a. Informant's Name/Relatio	nship (Type, Print)		19b. Mailin	g Address (Street	and Number or Ru	ral Route Numbe	er, City or To	wn, State, Zip	Code)
=	alth alth		Peter Enslein	n/Conserva	tor	1738	Wisconsi	n Ave. N	V Washin	etan.T	oc 2000	0.7
ָט ב	tem trem othe		20a. Method of Disposition		20b.	. Place of Dispo	sition (Name of natory or other place		Date		on - City or To	
2	Page ent o ht: If ry or		1 Burial 2 Cremation 4 Donation 5 Other		n State	Line		3/22/	2007	Suitla	and MD	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Maralla Hygiens. Depertment of Health and Maralla Hygiens. The important: I ferm 27 is marked other then "natural", or Iteme 23a or 28s-1 show eny injury or other traumatic event, the Marical Examinar must be notified at once.		21. Signature of/Funeral Service					ss of Facility Ft				Iome
ă	Depermine Depermine Important Import		Acres	5/111	<u> </u>			ensburg F				
			20a. Part Enter the disease,	or complications that	caused the de					<u>-</u>		Approximate
			shock, or heart failure. L	ist only one cause on	each line.							Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)			creatit	is					
	Examiner			Due to	o (or as a cons	equence of):						
		-	Sequentially list conditions,	b. Due to	o (or as a cons	equence of):						
	ed Islt	į	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹ 550.	0 (0) 20 0 0013	5445/105 517.						
	and F.trar	Examiner	that initiated events resulting in death) Last	c	o (or as a cons	edneuce ot).						
Š	icate be executed physicien and s the burial-transIt	E I			(,	
ò	cate phys the	dical		d								
o ≺	ding ling se as	/Me	IF FEMALE:	220 If yes o	utcome of preg	102004						
	ath c	an	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fe	etal death 3	Ectopic pregnanc	у		23d.	Date of deliv Month	ery Day Year
5	the a	Sic	1 ☐ Yes 2 ☐ No 9 🔀 Unknown	4∐Pre	gnant at time of snown	t death 5∟	Other (specify) _					,
	w requires thet the death certifi been signed by the attending p should be detached for use as	Physiclan/Me		itionet-bting to	dooth but not a	and the contract of the contra	- d-	on in Dard I	220 Did t	obacco uso	contribute to	the cause of death?
ñ	igne bed	ρ	Part II. Other significant cond	tuons contributing to	death out not r	esuiting in the U	nderlying cause giv	ven in Patti.				-
<u> </u>	inper s	ted							''	Yes 2□N	lo 3∏Prol	bably 4XJUnknown
3	law r es be 2 sh	be							24a. Was autor	an 2	4b. Were auto	opsy findings available ompletion of cause of
_	The ate h	Completed							perfo 1 ☐ Yes	rmed?	death?	
2	ien: rtifica stor, j	0	25. Was case referred to medi	cal				26. Place of Dea	th (Check only o			
>	yslc is ce direc	To B	examiner? 1 ☐ Yes 2 ☐ X No	Hospital: 1	Inpatient 2		t 3□ DOA Ott	ner: 4 🗆 Nursing H	lome 5 🗀 Resi	dence 6	Other (Speci	ify)
2	g Ph ler th leral		27. Manner of Death	/4.4.	e of Injury onth, Day Year)	28b. Time of Injury	28c. Inju	ry at	28d. Describe	how injury oc	curred	
	ndin ath. r: Aft	핥	1X Natural 5 Pen 2 Accident inve	stigation	Alli, Day 10ai/	injury		Yes 2□No				
2	Atte ecto by th	=		ld not be 28e. Pla	ce of Injury - At	t home, farm, str	eet, factory, office		28f. Location (umber or Rur	al Route Number,
5	al or	Certification:	4 🗆 Homicida	Bui	lding, etc. (Spe	icity)			City or 70	WII, State)		
	To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit			ying Physician: To t								
	P Ho P Fu	Medical	(Check only 2 Medic one)	al Examiner: On the	basis of exami anner stated.	ination and/or in	vestigation, in my	opinion, death occu	rred at the time,	date and pla	.ce, and due t	to the cause(s)
	To the within To the To the To the To the Comp	ž	29b. Signature and title at cert	ifier /	1	1	29c. Licen:	se number	2 2	29d. Date si	igned (Month,	Day, Year)
			> hell 1	eurolile.	. 1	()	()	201	12	3	110	10/
- 1	2		30. Name and address of pers	on who completed ca	use of death (II	tem 23a) (Type	Print)				. , _	/
1					_			Ua ak da s	PG 04	0026		
	Sta	ite	Dr. Tra Tann 31. Date filed (Month, Day, Ye	ar) 32.	Registrar's Sig	nature	TE 313,	Washingt	on, DC 2	UU36		
	Registr		MAR 22 200	7 /	1. 1.	July 1						
			HALL SE SEC.	- PIECE	-	/						

			For State Registrar	State of Maryla	-	artment of H			iene	17	110	33			
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day	Year	3. Time of	Death			
	Physicia /Medic		James Thaniel M	CCliones, J	Tr.			March	19, 200		6:47	P. M			
	Examin		4a. Facility Name (If not institution, give si			4b. City, Town, or			4c. County of						
			Fort Washington Ho			Ft. Wa:	shington If Under 24 Hrs.	0 D (Bist	Prince			- Familia			
	Funeral		5. Social Security Number 6. Sex	M 2□ F 7. Age (In)	rrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 8/2/62	y, Year) Country)						
	Director		578-78-5559 Usual Residence of Decedent					0/2/02		wasii	.,D.C	•			
	yland		10a. State 10b. County		City, Town or Lo		7 77 7 7 7			10	d. Inside Ci				
	a-fs	cto	Md.	P.G.		Temp	le Hills				X⊠Yes	2 No			
	or 28	Director	10e. Street and Number			10f. Zip Code		1	l0g. Citizen of W		try?				
	ath w	ia	6001 St. Moritz I				20748			S.A.					
	er de İtemi	Funeral		2. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of Hi f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecity Yes of No- Rican, etc.)		- America k, White, e					
36	irs aft	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 🎉 No	Specify:		Specify:	: E	lack				
ŏ	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f show the Medical Exana ar must be notified at		15. Decedent's Educ		16a. Dece	dent's Usual Occupa	ition	ion -	16b. Kind of Bu	siness/Ind	lustry				
218	e. en "n	nple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done d DO NOT use retired,)	ing							
7	filed wi Hygien other th	Completed		yrs.	T	ruck Driv			Private		lustry				
ī	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last) James T. McClior	oc Cr			18. Mother's Name Ruth Sn		Maiden Sumam	Θ)					
7	should ind Men marke	ဥ	19a. Informant's Name/Relationship (Typ.		10h Maili	ng Address (Street a			r City or Town	State Zin	Code				
Baltimore, Maryland 21215-0036	C/ 40 75 60		Jacqueline McClione			St. Morit						48			
ē,	s 1 and f Health item 27 other ti		20a. Method of Disposition	20	b. Place of Dispo	sition (Name of matory or other place		Date	20c. Location -	City or To	wn, State				
Ē	Pages nent of I ant: If ite		1 ⊈Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	Mem. Park	0.101	′ 07	Landove:	r, Mo	l.				
alti	글본란를 .		21. Signature of Funeral Service License					Sone Co	Tnc	•					
m	Depa Impo eny ii		Jany W.	Gray	4	Name and Address H.S. Wash 925 Burro	ughs Ave.	,N.E.,W	ash.,D.	C. 20	019				
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final											
	Physician		Immediate Cause (Final disease or condition	Cardio		rythmia					Onset and t	J64[I1			
ı	/Medical Examiner		resulting in death)	Due to (or as a con		May									
П		Į.	Sequentially list conditions, if any leading to immediate	Due to (or as a con	SMUOD Sequence of):	arry									
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
ó	exec an an rial-tr		resulting in death) Last	Due to (or as a con	sequence of):										
8760,	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	d													
9	entifica ling pl e as t	Physician/Medical	IF FEMALE:												
Вох	eath certific attending p I for use as 1	lan/	23b. Was decedent pregnant in the past 12 months?	Ic. If yes, outcome of pre	Fetal death 3	Ectopic pregnancy			23d. Date Mor	e of delive nth	•	Year			
	he de the c	ysic	1 Yes 2 No	4☐Pregnant at time 9☐ Unknown	ordeath 5L	Other (specify)									
P.O.	res that the designed by the long the leaded by the long detached		Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contr	ibute to th	e cause of o	death?			
rds	quires n sign uld be	ed by	Part II. Other significant conditions con	dh				1 🗆 Y	es 2 No	3 Prob	ably 4 □1	Unknown			
000	law requir as been si 2 should	Completed	Renal I	asufficie	ncy			24a. Was a		Vere autor	osy findings	available			
autopsy performen? 1 Yes 2000 10								leath?	2□ No	ause 01					
ita	Physician: this certifica ral director, p	Be	25. Was case referred to medical examiner?				26. Place of Deat								
Hospital: 1 Inpatient 2 AER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other.											1)				
Division of Vital Records,	ling After une	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time o	Work	rat ⟨? Yes 2 □ No	28d. Describe h	ow injury occurr	ea					
isio	teat feat tor:	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - /	At home, farm, st		163 2 110		treet and Numb	er or Rura	l Route Num	nber,			
Σ	P Sign	Certification:	4 Homicide determined	building, etc. (Sp	pecify)	,		City or Tow	m, State)						
	Hospital or 24 hours afte Funerel Dire tely filled in b			ician: To the best of my											
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edical	one)	er: On the basis of exam and manner stated.	mination and/or in							*/			
	To T Com	Σ	29b. Signature and title of certifier			29c. License			29d. Date signed			٦.			
mo D46741 March 19, 200							700-	7							
	(4)		30. Name and a ress of person who co Deepak Sache		(Item 23a) (Type, 117		eton Posi	-12 + 12 F	chinete:	n Ma	2074	1			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's S		. 1 TTATIG	ston Road	a, r.c. wa	2111110[[0]	IT INO	_20/4	4			
	Registr		MAR 2.2 2007	Been D.	Service .										

			For State Registrar	State of	Maryland		artment of I	Health and N		giene 07	11034
		ŧ	Decedent's Name (First, Middle	e, Last)	11		/		2. Date of Dea	th	3. Time of Death
	Physicia /Medic		MARCINE	ERITE	1/1	1RA	H4		Month March 2	26, 2007	3:10 A M
0	Examin		4a. Facility Name (If not institution	n, give street and numb	e street and number) 4b City, Town, or Lo			or Location ot Death		4c. County of Death	
			Charlotte Hall					otte Hall		St. Mary	
	Funeral		5. Social Security Number	6. Sex 7. 1 ☐ M 2 🙀 F	Age (In yrs. la	st birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	r, Year) Cou	place (State or Foreign intry)
	Director		364-22-4722 Usual Residence of Decedent		93				Sept. 5	, 1913 Mich	igan
	Maryland -f ehow		10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits
	the Marylan r 28a-f ehow	tor	Maryland Monte	OMOTV		01ney					1 ☐ Yes 2 🙀 No
	deeth with the ms 23s or 28s r must be notif	Director	10e. Street and Number	OMELY.		OTHEY	10f. Zip Code			10g. Citizen of What Cou	ntry?
	23s o	aiD	18012 Lafayett	e Drive			2	0832		USA	
	ems 23s	Funerai	11. Marital Status	12. Was Deced	ent Ever in U.S	. 13.	Was Decedent of i	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White	
, ,	or it		1 Never Married 2 Marr	ned 1X Yes 2 If Yes, Give	□No		1 ☐ Yes 2 🛣 No			Spacific	
کې ک	Z I Z I D-UUSO d within 72 hours after glene. er then "naturel", or ite the Medical Examina	d by	3 ₩ Widowed 4 Divorced		es:	10: 5				W	nite
77	n 72 n	Completed	15. Deceden (Specify only highe	st grade completed)		(Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most of worl ed)	king	16b. Kind of Business/li	ndustry
, c	with in the second seco	шc	Elementary/Secondary (0-12)	College (1-4	lor 5+)		retary	,,,		Federal G	overnment
2 3	Hygid Ant.		17. Father's Name (First, Middle,	Last)	Į.			18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
8,	id be ental ked o	To Be	Edward	M.	Cody			Mary	M	illick	
N	re, maryland ZIZI s I end 2 should be filed within Heelin and Mental Hyglene Item 27 is marked other then other treumatic event. In Min	-	19a. Informant's Name/Relations	hip (Туре, Print)		19b. Maili	ng Address (Stree	t and Number or Ru	ral Route Numbe	r, City or Town, State, Z.	p Code)
	end 2 end 2 eeith a n 27 is		John J. Murphy	y/Son		180	2 Lafaye	ette Drive	, Olney	MD 20832	
9	ore, iv		20a. Method of Disposition	2 MRamaval from St		ace of Dispo	sition (Name of matory or other pla	ace)	Date	20c. Location - City or 1	own, State
	Page nent ment the		1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (S			insfie	eld-Echol	ls 3/27	/2007	Charlotte H	all, MD
100	Daltimore, permit. Pages 1 el Department of Hee Importent: if Item eny injury or othe		21. Signature of Funeral Service	Licensee J	mode	4/ 1	Name and Addr Brinsfiel	ess of Facility Ld-Echols	Funeral	Home, P.A. arlotte Hal	1. MD 20622
1	-		23a. Part1. Enter the disease, or	complications that cau	sed the death.						Approximate Interval Between
	Physician		shock, or heart failure. List Immediate Cause (Final	Only one cause on eac	A TOTAL A	DI	CTOIL	N+11/E	11.10	Nics nor	Onset and Death
	/Medical		disease or condition resulting in death)	aDue to o	as a conseque	ence ot):	22 (120)	-IIVE,	LD116	HARAR	
	Examiner		Conventially list conditions	b	E 5811	2AT	DKL	FALL	RE		
	D =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due v (o	as a conseque	ence of):	17 1	1 /11			
	te be executed ysician and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	1100	TIUE	2 /	SOSE			
ç	If bU , tte be ex ysician and burial	E	, , , , , , , , , , , , , , , , , , ,	Due to (o	as a consequi	ence ou):	, ,				
1	# × 6	dicai		d							
	VISION Of VITAL MECONDS, P.O. BOX OX Attending Physician: The law requires that the death certifica relath. Totath. Sctor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as it.	by Physician/Med	IF FEMALE:	23c. If yes, outco	ome of pregnan	icv				23d. Date of deli	10.EU
Ġ	Bath atten	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birt	h 2 ☐Fetal	death 3[Ectopic pregnand Other (specify)	су		Month	Day Year
(by the datached	isk	1 □ Yes 2 No 9 □ Unknown	9□ Unknov							
٥	HECOIDS, P.O. BOX he law requires that the death cert e has been signed by the attendin tge 2 should be detached for use	y Pł	Part II. Other significant condition	ons contributing to dea	th but not resu	lting in the u	nderlying cause g	iven in Part I.	23e. Did to	obacco use contribute to	the cause of death?
	COLDS, w requires been sign should be	pe p	MARMIA	! 					17/1	′es 2∐No 3∏Pro	bably 4 Unknown
	aw re	piet	CEREBRA	IL ATR	D PHU				24a. Was	an 24b. Were au	topsy findings available
	The lav	Completed		77-1-13	111/				autop perfo	rmed? death?	ompletion of cause ot 2 ☐ No
w.	VICAL P	Bec	25. Was case referred to medica examiner?		O - 111 (VII-1074) C.	7,172		26. Place of Dea	th Check only o	A	
	OT V Physic rthis ce	2	1 ☐ Yes 2 No	Hospital: 1 🗆 Inj	patient 2 🗆 E	R/Outpatie	nt 3 DOA	ther: Nursing H	ome 5 Resid	dence 6 Other (Spec	ufy)
	ON O	ë.	27. Manner of Death 1 Natural 5 ☐ Pendir	28a. Date of (Month)	Injury Day Year)	28b. Time o Injury	t 28c. Inju	ury at ork?	28d. Describe h	now injury occurred	
13.	ISION Atending death. ctor: Afte	cati	2 Accident investi 3 Suicide 6 Could	gation]Yes 2 □No			
3	or At effect Direction by	Certification:	4 Homicide determ	ained 288. Place C	of Injury - At hor g, etc. (Specify,	ne, farm, st)	reet, factory, office	9	City or Tox	Street and Number or Ru vn, State)	ral Houte Number,
B	Hospital 24 hours e Funerel I		29a. Certifier 1 Certifyin	ng Physician: To the h	est of my know	vledna dasi	h occurred at the	time, date and place	, and due to the	cause(s) and manner as	stated.
21	DIVISION To the Hospital or Attention 24 hours effer death To the Funeral Director:	Medical	(Check only 2 Medical	Exeminer: On the bas and manne	is of examinati	on and/or in	ivestigation, in my	opinion, death occu	rred at the time,	date and place, and due	to the cause(s)
	To the within 2	Me	29b. Signature and title of certifie	or I i			29c. Licer	ise number		29d. Date signed (Month	n, Day, Year)
	a \			HIN			(V)	12906		3/20/2	7
	DCX		30. Name and address person	mpleted cause	of death (Item	23а) (Туре	Print)	700		10-1	
	4.5		Ahmed Heshna				, Maryla	nd 20855	<u>.</u>		
	Sta		31. Date filed (Month, Day, Year)	- AT	istrar's Signat	A.	Swell !				
	Registi	ar	MAR 2	9 2007		M. J					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Month **Physician** 2:10P M March 25, Martin Elisha /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles 7597 Olivers Shop Road LaPlata 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 XM 2 ☐ F Director 89 Sept. 1, 1917 Kentucky 400-22-6614 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ıral", or items 23a or 28a-f st I Examiner must be notifled 1 TYes 2 No Director Maryland Charles LaP1ata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 2 and 1 injury or other traumatic event, the Medical Examiner must be mone. 20646 USA 7597 Olivers Shop Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 TXYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Machinist/Supervisor LAU Industries 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Della Frailey Hugh Martin 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 7597 Olivers Shop Road, LaPlata, Maryland 20646 Armetha Martin/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State **Brinsfield-Echols** 3/28/2007 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A e of Funeral_Service oun MOD6 41 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Colorectal Cancer /Medical Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a consequence of The law requires that the death certificate be executed as the burial-transi Exami COPD and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical H T N IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an 1□ Yes 2₩No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 2 X No 1 TYes 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. reral Director; / 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) ျှ D55027 3/26/2007 who completed cause of death (Item 2%a) (Type, Print)

State

Division or Vital Records, P.O. Box 68760,

AR 2 9 Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Dr. Manoj Panwala,

Charlotte Hall, Maryland 20622

Registrar's Signature

			For State	State of Mar	yland						')	007	11037
			Registrar 1. Decedent's Name (First, Middle, Las	rf)		Cer	tificate o	t Deati	n	2. Date of Dea	Reg. No.	UUI	3. Time of Death
п	Physicia	an	2 () (Ma	113		Month	Day	Year	3:40 AM
¥	/Medic Examin		4a. Facility Name (If not institution, give	e street and number) ,			4b. City, Town	, or Location	n of Death	MARCH	4c. Cou	nty of Death	
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	Funeral		5. Social Security Number 6. S		. ,	st birthday)	If Under 1 Ye Months Day		er 24 Hrs. Min.	8. Date of Birt (Month, Da	th y, Yea <i>r</i>)	9. Birth	nplace (State or Foreign untry)
	Director	. L	284-24-9615 Usual Residence of Decedent	□ ^{M 2} 3 4 7 6)	Yrs.				1/14/	1931	Ken	tucky
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	ter de item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No). 13. 1	Vas Decedent of f Yes, specify C	uban, Mexic	can, Puerto	Rican, etc.)		Black, White	
2-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:			l∐Yes 2 ⊠ 1	lo Specii	fy:		Spe	cify: b	lack
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	47		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused t	he death.					-)	Approximate Interval Between
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10	/Medical		resulting in death)	Due to (or as a		ence of):	1100,00	(Audio /)	90				7 /
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Box	The law requires that the death certific the has been signed by the attending to page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at t	2 ☐ Fetal	death 3[Ectopic pregna				23d.	Date of del Month	ivery Day Year
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<u> </u>	The cate h	Com								1 ves	ormed? 2 □ No	deaty? 1 Z Yes	
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0	Phys r this ral dir	- T	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	у	ER/Outpatier 28b. Time o	IL SU DOA	njury at Nork?	Nursing H	ome 5 ☐ Res 28d. Describe			cify)
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical		hysician: To the best o miner: On the basis of and manner stat	examinat								
	o the vithin of the comple	Med	29b. Signature and title of certifier	and manner state			29c. Lic	ense numb	er		29d. Date si	gned (Mon	th, Day, Year)
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	01		31. Date filed (Month, Day, Year)	32. Digistra	ır's Signal	ture 600	J M. W	DIFE	ST.	15A111	MO12,	WALY,	19 nd 2178/
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician David Oakley Moore, Jr. MARCH 22 2007 5:14 ΑM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner CIVISTA MEDICAL CENTER LAPLATA CHARLES If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year 1₩ 2□ F Months Days Hours 216-76-4947 49 Director 19, 1957 Washington DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Maryland Charles LaPlata 1 ☐ Yes 2 ☑ No item 27 is marked other than "natural", or items 23a or 28a-f st other traumatic event, the Medical Examiner must be notified Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 1 Magnolia Lane 20646 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify ģ Specify.white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11th heavy equipemnt Operator construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fand Mental I David O. Moore, Sr. Shirley W. Gaines ٩ and 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tem 27 is Debbie Willis - sister 5851 Partlow Rd. Fredericksburg VA 22553 20b. Place of Disposition (Name of cemetery, crematory or other place) March 22 2007

Metropolitan Funeral Service Pages 1 20a. Method of Disposition 20c. Location - City or Town, State 70 Important: If it any injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of drying, such as cardiac or respiratory arrespicatory arresponds, or heart failure. List only on cauch on each line. Immediate Cause (Final NOUMONTA WITH KNOW **Physician** 3 Pr 6 disease or condition resulting in death) /Medical Examiner THORNET WER. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi Due to (or as a consequence of): P.O. Box 68760 physician pe Physician/Medical the as ed by the attending person detached for use as IF FEMALE: use a 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9□Unknown 9∏Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 2 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page certificate 1 ☐ Yes 2 ☐ No 1∐ Yes 2D No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2**X** No 1 Inpatient P 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred After t 28c. Injury at Work? Certification: or Attending Injury 1√Natural 2 ☐ Accident (Month, Day Year) 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 ☐ Homicide Hospital 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

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31. Date filed (Month, Day, Year)

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and address of person who completed cause of death (Item 23a) (Type, Print) NAT

2007

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32. Registrar's Signature

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M.D

29d. Date signed (Month, Day, Year)

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Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 20, РМ 2007 4:35 Jennifer Baker McLeod March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, Yea 1111 y 29, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Washington D.C Year) 1946 5. Social Security 31755 215-04-8355 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2XX Days Hours 60 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Directo Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21403 United States 325 Hillsmere Drive Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working markad other than College (1-4or 5+) Нудівлв. Elementary/Secondary (0-12) Instructor Public Education 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other treumetic event, once. 17. Father's Name (First, Middle, Last) Doris Genevieve Richardson Arthur Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Annapolis, Maryland 21403 John H. McLeod / Husband 325 Hillsmere Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 3/21/2007 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, and the sequential sequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the attending esn IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1/ Yes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed After this certificate I 1 Yes 2 □**/**No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending 1 🗔 Matural 1 ☐ Yes 2 ☐ No М investigation 2 Accident Diractor: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certif 200 rson who completed cause of death (Item 23a) (Type, Print) 30. Name an 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 22, ^{Day} 2007 Rodney Jack Moore 3:41 PM™ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 14603 Duckett Road Prince George's Brandywine If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Months Days 1**⊠** M 2□ F 236-66-7191 62 March 24, 1944 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2⁄☐ No Maryland | Prince George's Brandywine 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 14603 Duckett Road 20613 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician 12 Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Orville Moore Thelma Myers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeff Moore - Brother O. Box 322, Fairmont, West Virginia 26552 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans' Cemetery 3-28-07 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee 3035 Old Washington Road M01391 Klight Huntt Funeral Home Waldorf, MD 20601 Pail. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performer? 1☐ Yes 2☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

or Vital Records, P.O. Box 68760

requires that the death certificate be executed sician and burial-trans physician s the burial as attending p led by the a s been signed b should be deta page 2 s or Attending Physician; this : After thi death. after death Director: / within 24 hours aft

To the Funeral Di

completely filled in

Be Completed by Physician/Medical Examiner

Certification: To

Medical

F140500

MAR 2 6

31. Date filed (Month, Day, Year)

Physician

/Medical

Examiner

Funeral Director

Be Completed by

ပ

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Me Ital Examiner must be notifiled at

Physician

/Medical Examiner

Baltimore, Maryland 21215-0036

State Registrar

D001923

Physician
/Medical
Examiner

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 **Physician** /Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and 'completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BENITO S. CHAID 1340 South

1 - For State Registrar		C	ertificate o	f Death	Reg.	No. 2007	1104
1. Decedent's Name (First, Middle, Last)	1	۸	_		2. Date of Death Month 2	Day Year	3. Time of Death
		DORE	SR		3	Day 20 Y87	1635 M
4a. Facility Name (If not institution, give s	treet and number)	001	4b. City, Town	or Location of Death		4c. County of Death	
reninsula regione	of Medica	1 Center	e Dale	sbury		Wicomi	
212-26-1626	M 2□F 7. Age	(In yrs. last birtho	Months Day		8. Date of Birth (Month, Day, Ye	Cou	place (State of Foreign ptry) PULANO
Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
Macyland Wicomic	e.	DEIN	PAR				1 Yes 2 No
10e. Street and Number	1	<u> </u>	10f. Zip Code		10g.	Citizen of What Cou	ntry?
1001 PINE ST	REE		2187	5		USA	
1001	12. Was Decedent E	ver in U.S.	13. Was Decedent o	Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ameri Black, White,	
1 ☐ Never Married 2☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 XYes 2 No If Yes, Give Year or Dates: 1€		1 ☐ Yes 2 N		, Tilodi, 616.	7	ec K
15. Decedent's Educ (Specify only highest grade	cation	16a. De	ecedent's Usual Occ	upation e during most of work	166	. Kind of Business/In	dustry
Elementary/Secondary (0-12)	College (1-4or 5+)	fe. DO NOT use reti	red)	ang	1/200-	
12 +	- a	16	zuck I	PRIVER		NONE	
17. Father's Name (First, Middle, Last)	* D F			18. Mother's Nam	e (First, Middle, Mai		
	ORE					INCLER	
19a. Informant's Name/Relationship (Type	pe. Print)		O (1	et and Number or Rui	1.	m 1	· · · · · · · · · · · · · · · · · · ·
20a. Method of Disposition	CCHSIA		isposition (Name of			Location - City or T	31804
1 Burial 2 □ Cremation 3 □ R	emoval from State	cemetery,	crematory or other	lace)	200	Elecation - City or 1	own, State
4 □ Donation 5 □ Other (Specify)		W=T:pgg	IN CEMETE		4-07	SUANTICO,	Mich
21. Signature of Funeral Service License Hladys B. SZ	tewart		Stewar 821 We	ress of Facility Thunera Strad 5	1 Home Alisbury	mD 2180)/
23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused to be cause on each line	the death. Do not	enter the mode of d	ying, such as cardiac	or respiratory arrest,	W = 8-10	Approximate Interval Between
Immediate Cause (Final disease or condition	H	ponte	Encen	hala nar			Onset and Death
resulting in death)	Due to (or as	onsequence of)					- (7)
Sequentially list conditions, b		liver	Citch	csis			3 years
if any, reauring to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	Consequence of,					
that initiated events resulting in death) Last	Due to (or as a	consequence of):	,				
	Due to (or as a	consequence on	•				
d							
IF FEMALE:	3c. If yes, outcome p	of pregnancy				Ond Date of deli-	
in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	☐ Fetal death	3 ☐ Ectopic pregnat			23d. Date of deliv Month	Day Year
1 □ Yes 2 □ No 9 □ Unknown	9□Unknown	o or goall	CE Carer (specify)				
Part II. Other significant conditions con	tributing to death but	t not resulting in th	ne underlyjng cause	given in Part I.	23e. Did tobac	co use contribute to	he cause of death?
- Consentivo	Caml	o myon	other		1 ☐ Yes	2 No 3 Pro	bably 4 🗗 Unknow
- 101	P	0//	/E /		24a. Was an	24h Wara sut	nnev findinge availabl
- (Manc	, Jun	al /	/ aille		autopsy performed	prior to co	opsy findings available impletion of cause of
05 Manager 1 1					1□ Yes 2⊡	Mo 1 □ Yes	2□ No
25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	4 00000	ationt all soal (thor:	th (Check only one)		
27. Manner of Death	28a. Date of Injury	y 28b. Tim	ALIENT SELECT	4 LI Nursing Ho	ome 5 ☐ Residenc 28d. Describe how	e 6 ☐Other (Speci injury occurred	Ty)
1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Inju	iry V	ork? □Yes 2□No			
3 Suicide 6 Could not be	28e. Place of injur	ry - At home, farm	, street, factory, office			t and Number or Rur	al Route Number,
4 ☐ Homicide determined	building, etc.	. (Specify)			City or Town, S	rate)	
				time, date and place			
		examination and/		y opinion, death occu			
29b. Signature and title of certifier		11	29c. Lice	nse number	29d.	Date signed (Month,	Day, Year)
A 20th	3 /	for	un i	7-2005	0	3/20/	4
30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Ty	rpe, Print)	9-2005 Wisian St.			1 HD2/
RENITO S.CA	100) 1	242 1	1 4 1	: C4	CXX	1 Notes	1 Mnsi
		וה עדכ	are to	VISION OI	() allo	/	4 100/1

State

Registrar

MAR 2 2 2007

			1 - State Registrar		State of M	aryland		artment of I tificate of		d Mental Hy	giene 🕦	07	11042			
is To	Physici		1. Decedent's Name (First, Middle, Las	•	d н.	Nguy	ven		2. Date of De Month March	22, 200	7 ^{Yeer}	3. Time of Death 8:45 P M			
-	/Medio Examin	47	4a. Facility Name (If n Prince Geo					4b. City, Town, Che	everly			y of Death CE Ge	orge's			
AP.	Funeral Director		5. Social Security Num 579-23-175	6 1	ex 7. Ag ☑ M 2☐ F	ge (In yrs. id 80	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	Irs. 8. Date of Bir in. (Month, Da April	1926 14, 1926	9. Birth Cou V	place (State or Foreign ntry) 1etnam			
	yland how		Usual Residence of D 10a. State 1	10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits			
	8a-f e	ctor		Prince (eorge's				ınham				1⊠Yes 2□No			
	th with the 23a or 2	al Dire	9615 Hux		<i>7</i> e			10f. Zip Code	06		10g. Citizen of	What Cou USA	ntry?			
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or Itama 23a or 28a-f show any injury or other traumatic event, Ira Medical Examinat must be notified at ance.	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Decedent Armed Forces 1 Tes 2 1 If Yes, Give Year or Dates:	?		Was Decedent of I I Yes, specify Cub I ☐ Yes 2X No	Hispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No lerto Rican, etc.)	Speci	ick, White	can Indian, , etc. etnamese			
2	72 hou	ted		5. Decedent's Ed			16a. Dece	dent's Usual Occu	pation	working	16b. Kind of E					
2121	within riene.	Completed	Elementary/Second		College (1-4or	5+)	life.	Soldier	d)	working	GOT	æmm	ent			
and ;	d be filed ental Hyg cad othe c event,	To Be C	17. Father's Name (Fi	irst, Middle, Last) V. Nguye		,				Name (First, Middle at T. Die		me)				
Maryland 21215-0036	nd 2 shoul lith and Me 27 is mark r traumati	Ē	19a. Informant's Nam Thuong N	, ,	Type, Print) (Son)					Rural Route Numb			p Code)			
Baltimore,	Pages 1 arent of Hearnt: If Item			Cremation 3	Removal from State	Ce	emetery, crer	sition (Name of natory or other pla	1	Date	20c. Location					
Baltii	permit. F Depertme Importer any injur			4 Donation 5 Other (Specify) Chesapeake Crematory 3/26/2007 Beltsville, MD 1. Signatur of Fineral Sovice Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham MD 20706												
J.				failure. List only	one cause on each	ine.	. Do not ent	er the mode of dy	ng, such as card	diac or respiratory a		10700	Approximate Interval Between Onset and Death			
24	Physician /Medical		Immediate Cause (Findisease or condition resulting in death)	inai	a Athe			Cardio	ascular	Disease			10 years			
	Examiner		haze-revasarian an occu				ryethn	nia					l year			
	sit s	lner	Sequentially list cond if any, leading to imm cause. Enter Underly	intions, nediate ying	Due to (or as	a consequ	uence of):									
60,	icate be executed physician and s the burial-transit	al Examiner	Cause (Disease or in) that initiated events resulting in death) Las		c. Due to (or as	a consequ	uence of):									
68760,	ficate physics the	edical			_ d.						-					
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 7 9 Unknown	onths?	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnanc Other (specify)	у		1	ate of delive	rery Day Year			
rds, P	quires that n signed b uld be deta	þ	Part II. Other signification Chronic (ontnbuting to death			nderlying cause g	ven in Part I.				the cause of death? bebly 4 Unknown			
Division of Vital Records,	he iaw requir e has been si ige 2 should I	Completed			Bleeding						psy ormed?	prior to co death?	opsy lindings available ompletion of cause of			
ita	ian: T	Be Co	Parkinson 25. Was case relerred	ns Disea d to medical	se				26. Place of	1 ☐ Yes Death (Check only	2⊠ No one)	1 🗆 Yes	2 □ No			
>	hysici his ce I direc	To E	examiner? 1 ☐ Yes 2 2 No	0	Hospital: 1 Inpati	ent 2	ER/Outpatier	nt 3 DOA	her: 4 🗌 Nursin	g Home 5 ☐ Res	idence 6 🗆 Ot	her (Spec	ify)			
ion o	or Attending Physician: The I after death. Director: After this certificate ha in by the funeral director, page		27. Manner of Death 1 X Natural 2 ☐ Accident	5 Pending investigation	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time o Injury	28c. Inju			how injury occu					
Divis	al or Attends after death	Certification:	3 Suicide 4 Homicide	6 Could not b determined	e 28e. Place of In building, e	jury - At ho tc. (Specify	me, farm, str	eet, factory, office			Street and Num wn, State)	ber or Rui	ral Route Number,			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical (29a. Certifier (Check onl) 2 one)	Certifying Ph	nysician: To the besi niner: On the basis and manner s	эг өхаулупан	wledge, deat tion and/or in	h occurred at the t vestigation, in my	me, date and plopinion, death o	ace, and due to the courred at the time,	cause(s) and m	anner as , and due	stated. to the cause(s)			
)	To the comp	M	29b. Signature and to	ne of certifier	Hen	My		29c. Licen	se number 3273		29d. Date sign	ed (Month	Oay, Year)			
_	(3)		30. Name and addres Rebath	ss of person who y Murthy	completed cause of	death (Item 61	30 Lar	Print) adover Ro	ad, Che	verly MD	20785					
*	Sta Registi		31. Date filed (Month,	Day, Year) 3 2007	32. Regist	rar's Signa	all)	•								

Funeral

Director

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items 23a

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"natural"

the Maryland

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dat **Physician** 2:154 Nielsen Junior March 22,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SALISBURY, MD. 21804 WICOMICO & NURSING CENTER SALISBURY REHAB 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Min. Days Hours 1⊠M 2□F 147-28-0987 9/14/1935 71 New Jersey Usual Residence of Decedent 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1508 Arbutus Drive 21804 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. XYes 2 No fYes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: lf Yes, Give Year or Dates: Navy white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) US Postal Service 18. Mother's Name (First, Middle, Maiden Sumame) Mary Clausen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1508 Arbutus Dr., Salisbury, MD 21804 20c. Location - City or Town, State Salisbury, MD 240T10Way Fufferal Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes 2 1 26. Place of Death (Check only one, 4 Privaring Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🗓 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	ryland /		rtment of tificate of			Re	g. No.	007	110	1,1,
	Physici	an	1. Decedent's Name (First, Middle, Last)		Cm				L	2. Date of Deat Month Iarch	12ay	2007	3. Time of E	Death M
	/Medio Examin		Emmanue1 K. 4a. Facility Name (If not institution, give		DT.		4b. City, Town,	or Location of		arcii		nty of Death	1400	
	LAGIIII	CI	7620 Maple Ave	·. #531			Tal	koma Pa	ark			Montgo	omery	
	Funeral		Social Security Number 6. Security Number		(In yrs. last b		If Under 1 Year Months Days		Min.	B. Date of Birth (Month, Day,	Year)		lace (State or stry)	Foreign
	Director		430-78-9725 Usual Residence of Decedent		73	Yrs.			A	pr. 5,	1933	Gl	nana	
	yland how		10a. State 10b. County		10c. City, To	wn or Lo	cation					1	0d. Inside City	
	80-f	ctor	Maryland Montgor	nery			T	akoma I	Park				1 X Yes 2	2 No
	with th	Funeral Director	10e. Street and Number	// = O.4			10f. Zip Code	200	010	1	0g. Citizen	of What Cour	•	
	ns 23	eral	7620 Maple Ave.	#531 12. Was Decedent E	ver in U.S.	13. V	Vas Decedent of	209 Hispanic Orig		fy Yes or No-	14. F	Ghana Race - Americ		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural; or items 23a or 28a-f ahow any figury or other treumatic event, I'm Medical Examinal must be notified at anone.	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 █ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	0		Vas Decedent of Yes, specify Cul ☐ Yes 2∑ No		Puerto Ri	ican, etc.)		Black, White, cify: Af	etc. Frican	
21215-0036	72 hou	Completed	15. Decedent's Edu (Specify only highest grad		16	a. Deced	ent's Usual Occu	pation	of working		16b. Kind o	f Business/In	dustry	
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2	Hygier Hygier ther ti		17. Father's Name (First, Middle, Last)	8		P	rofesso:			First, Middle, M	Maiden Sun	Privat	:e	
and	ld be f ental 1 ked of c eve	To Be	Samuel T. Kwas	si Kwao Oh	emeng			io. mound	S (tame)	Dora I				
Baltimore, Maryland	2 should be f and Mental h is marked of reumatic ever		19a. Informant's Name/Relationship (Ty			b. Mailin	g Address (Stree	and Number	r or Rural i				Code)	9
Z .	and 2 ealth a m 27 I		Emmanuel K. Oheme	eng, Jr./S				ry Ave		lrose I				
ore	ges 1 if of H if its		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ F	emoval from State	cemet	ery, cren	sition (Name of natory or other pla		Da		20c. Locatio	on - City or To	wn, State	
ij	it. Pa intmen intent: injury		4 ☐ Ronation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Α.		-	s Cremat	-				Clintor		
Ba	Depa Impo		5	ewar I	11				ى د	ewart I				
			23a. Part1. Enter the disease, or complishock, heart failure. List only or	cations that caused t	he death. Do	o not ente						1., 50	Approximate Interval Between	990
	Physician	Ì	Immediate Lause (Final disease or condition a. ASCVD											
	/Medical Examiner		resulting in Seath)	Due to (or as a									ME	
		-	Sequentially list conditions, if any, leading to immediate	Due to (or as a	tes Me		us							
	od ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
Ö,	e exer	Ex	resulting in death) Last	Due to (or as a	consequence	e of):								
8760,	icate be executed physician and s the burial-transit	dlcal		J		-								
Box 6	certifi nding use as	√Me	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome o							23d.	Date of delive	erv	
	it the death certific by the attending p tached for use as	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown			Ectopic pregnand Other (specify)	су				Month	Day Ye	ear
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ords,	v requires t been signe should be	ted by						TOTAL T					ably 4 ∏Ur	
Division of Vital Records,	2 2 2	Completed								24a. Was an autops perform	y	prior to con death?	psy findings av mpletion of cau	
ita	Physician: The I this certificate har ral director, page	BeC	25. Was case referred to medical examiner?					26. Place	of Death (1 Yes 2 Check only on		1 1 1 65	2 140	
<u>5</u>	Physic this ce al dire	၉	1 XYes 2 No	1	t 2 ER/C					∍ 5 Aeside			y)	
ou	ding P. h. After funera	tlon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b.	. Time of Injury	28c. Inju	uryat ork?]Yes 2.∐N	1	d. Describe ho	w injury oc	curred		
<u>Visi</u>	Atten r deat ector: by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur	y - At home,	farm, stre				f. Location (St		mber or Rura	l Route Numb	θ/,
ā	ital or urs afte rai Dir ited in		T TOTAL COMMENT	building, etc.	(Spacily)					City or Town	, State)			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a Certifier (Check only 2 Medical Examination)	ner: On the best of and manner state	examination a	ge, death and/or inv	occurred at the t estigation, in my	ime, date and opinion, death	place, an	d due to the call at the time, da	ause(s) and ate and plac	manner as si ce, and due to	tated. the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	. \/ .		-		se number		2!		ned (Month,		
0			Mu oran	00	20 C	-		D00428			Marc	h 12,	2007	
1	-		30. Name and address of person who co				Print) Medical	Park D	r., 9	ilver (Sprine	, MD '	20902	
	Sta		31. Date filed (Month, Day, Year)					D			- P 1 }	,		
	Registr	ar	MAR 2 2 2007	Dien D	's Signatur	ARTH								

DHMH 17 Rev 1/2001

			1 _ State		artment of Health and I rtificate of Death	Mental Hygie Reg.	0000	11016					
			Registrar 1. Decedent's Name (First, Middle, Last)		imodio oi bodiii	2. Date of Death		3. Time of Death					
	Physici /Medio		Leo William O'Neill III			March 17	2007 Year	8 AM M					
	Examin		4a. Facility Name (If not institution, give street and num	ber)	4b. City, Town, or Location of Death	1	4c. County of Death						
	## ## ## ## ## ## ## ## ## ## ## ## ##		11870 Highview Circle 5. Social Security Number 6. Sex 7	. Age (In yrs. last birthday)	Lusby If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Calvert 9. Birthplace (State or Foreign						
ь	Funeral Director		218–54–7592 15€M 2□F	55 Yrs.	Months Days Hours Min.	(Month, Day, Ye Dec 2 195	Day, Year) Country) 1950 Missouri						
	pu »		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cotion		1,	Od. Inside City Limits					
	//aryla	ō	Maryland Calvert	Lusby	cation			1 ☐ Yes 2 ☐ No					
	r 28a- notifi	rect	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cour	ntry?					
	th with 23a o	a D	11870 Highview Circle		20657	U	nited Stat	ces					
9600	be filed within 72 hours after death with the Maryland that Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by Funeral Director	Armed Ford 1 ☑ Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ Yes Give	ces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: Whit	etc.					
21215-0036	within 72 h iene. than "natu the Medical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	4or 5+) (Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	rking	b. Kind of Business/Ind	·					
	lygi lygi lt, t		12th 17. Father's Name (First, Middle, Last)	Lot M		ne (First, Middle, Maid	ar Dealers den Surname)	snip					
lan	should be filed withir and Mental Hygiene. marked other than imatic event, the M	To Be	Leo W. O'Neill, Jr.		Aloise	Ward							
	- a o =		19a. Informant's Name/Relationship (Type. Print) Ann O'Neill — sister	l .	ng Address (Street and Number or Ru February Circle			*					
altimore,	permit. Pages 1 and 2 Department of Health : Important: If item 27 It any Injury or other tra once.		20a. Method of Disposition 1 □ Burial 2 XI Cremation 3 □ Removal from S 4 □ Donation 5 □ Other (Specify)	Antomy Gi	matory or other plamarch 24 Lfts Registry	2007 Ha	c. Location - City or To						
Balt	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral Service Licensee		2. Name and Address of Facility Ra 05 Broomes Is. rd		eral Home oublic MD 2	20676					
			23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea					Approximate Interval Between Onset and Death					
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Bue to (or as a consequence of):										
1	/Medical Examiner		Due to (c	r as a consequence of):									
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	or as a consequence of):									
	ecuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (c										
8760,	cate be executed physician and the burial-transit	al Ex	Due to (c	r as a consequence of):									
687	ficate physics the	edical	d										
P.O. Box	The law requires that the death certific the has been signed by the attending p age 2 should be detached for use as	Physician/M	in the past 12 months?	int at time of death 5	⊒Ectopic pregnancy]Other <i>(specify)</i>		23d. Date of delive Month	ery Day Year					
	w requires that been signed by should be deta	by	Part II. Other significant conditions contributing to dea	ath but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the						
I Records,	(0 12	Completed				24a. Was an autopsy performed 1∐ Yes 2∑	prior to co death?	opsy findings available mpletion of cause of					
Vital	Physician; The this certificate har all director, page	Be	25. Was case referred to medical examiner?		Lou	ath (Check only one)							
or	ਨ ≑ ਲ	은 -	1 ☐ Yes 2 No Hospital: 1 ☐ In 27. Manner of Death 28a. Date or	patient 2 ER/Outpatier		lome Residence	e 6 Other (Specification)	(y)					
ion	Attending Frideath. ector: After by the funer.	tion	1 Natural 5 ☐ Pending (Month 2 ☐ Accident investigation	n, Day Year) Injury	f 28c. Injury at Work? M 1 □ Yes 2 □ No	200. 2000.120 71047	njary occurred						
Division	after dea after dea I Director	Certification:	3 Suicide 6 Could not be	of injury - At home, farm, str g, etc. <i>(Specify)</i>	eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura State)	al Route Number,					
	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier Check only one) Check only and manner: On the ba	sis of examination and/or in	h occurred at the time, date and place evestigation, in my opinion, death occur	e, and due to the caus urred at the time, date	e(s) and manner as s and place, and due to	stated. o the cause(s)					
	To the within To the comp	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month,						
			has fall	MO	0059061		larch 19 20	JU /					
			30. Name and address of person who completed cause A. Patel MD 110 Hospit		Print) Se Frederick MD 20	1678							
	Sta	ite	31. Date filed (Month, Day, Year) 32. Re	gistrat's Signature	A. W.	7070							
	Registi		MAR 2 0 2007	Bern. B.	MARI								

DHMH 17 Rev 1/2001

07-02291	
Andrea Petty	

Andrea Petty		Signal Si	tate of Maryla		artment of rtificate of		d Mental F		Reg. No.	007 1104	
Physician Medical Examine		1. Decedent's Name (First, Midd					_	2. Date of Dea Month	Day Yea	3. Time of Death 7 0823 hrs	
		ANDREA LYN 4a. Facility Name (if not institution		mber)	1	b. City, Town, or	Location of Deal	March 25	4c. County o		
		8 Dantry Ct. 12085	Acton Lane	Apt A		Waldorf			Charles		
Funeral Director	- 1	5. Social Security Number 213-88-9484	6. Sex	7. Age (In yrs. I		If Under 1 Yea Months Day		_		9 Birthplace (State or Foreign VA •	
any	-	Usual Residence of Decedent 10a. State 10b. County	,	Inc. City	Town or Locati	00			10d. Inside City Limits		
			IARLES	Toc. Oity,	TOWITO! LOCAL	WALDO	RF			1 Yes 2 X No	
the Maryland a or 28a-f show tified at once.	3 2 1		75 Acton Lan	<u> </u>		10f. Zip Code			10g. Citizen of Wh	at Country?	
h the N			ON LANE			20	601		U.S.A	•	
or items 2	4.		Married Armed Fo	2 X No	If Y	s Decedent of His es, specify Cubar	n, Mexican, Puert		White	- American Indian, Black, , etc. WHITE	
urs afte	<u>-</u> ≏	3 Widowed 4 Div 15. Decedent's Education (Spe	ivorced If Yes, Give Year or Dates: ecify only highest grad			Yes 2 X No		work done	Specify: 16b. Kind of Bus		
5-0036 ed within 72 hour tygiene. other than "natu	alaidii	Elementary/Secondary (0-12)			during m	ost of working life	. DO NOT use re		OWN I		
21: 21: be fill rked ent,		17. Father's Name (First, Middle JOHN ANDRE)						e (First, Middle, TOWN	Maiden Surname)		
Should I and Mer 7 is mar natic ev	2	19a. Informant's Name/Relations JOHN A. PE		FD		Address (Stree			mber, City or Towr	n, State, Zip Code)	
	L	20a. Method of Disposition	TII-FAIII			ition (Name of cer		Date		City or Town, State	
Baltimore, permit Pages I ar Department of He, Important: If ite	- 1	1 XBurial 2 Crematio			crematory or oth ITY ME	ner place) M • GARDI	ENS 3-	-31-07	WALDON	RF,MD.	
altir	1	4 Donation 5 Other S 21 Signature of Funeral Service	pecify: e Licensee	04/9 (AI. SERV			
		Much (23a. P. I. Enter the disease, or	The same is a stant as	nunced the death					VICE, P. A		
Physician /Medical Examiner		failure. List only one cause failure cause (Final disease or condition resulting in death)	e on each the. e a. <u>Atheros</u>		cardiova	scular dis			y methadone	Between Onset and	
- 1. 12 m	ŀ	Sequentially list conditions,	b.	consequence o	"). HICOXI	Catton					
	5	if any, leading to immediate cause. Enter Underlying Cause		consequence o	f):						
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O, e be exe ysician a burial -		X UNPENDED	X AMENDED	#4a ,28f, p 7,28a-f,	er, 10e, perME, 68	perFH, C8 67, 5/16/0	68, 6/1607 7 TI	TT			
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after cleath certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		F FEMALE: 3b. Was decedent pregnant in t past 12 months? 1 Yes 2 No 9 V Un	the 23c. If yes, of 1 Live bit 4 Pregn.	outcome of preg irth ant at time of de	nancy 2 Fe	tal death 3 ner (Specify)	Ectopic pregr		23d. Date of Month	delivery Year	
J. B.		Part II. Other significant condi	3 OHKIO		esulting in the u	nderlying cause g	given in Part I	23e. Did t	tobacco use contri	bute to the cause of death?	
P.O. res that the signed by be detach	n o							1Ye	es 2 🗸 No 3	Probably 4 Unknown	
Division of Vital Records, tal or Attending Physician: The law require is after deand and physician: The law require all brirector: After this certificate has been siled in by the funeral director, page 2 should be deficient. To De Computation	palaidillo							24a. Was auto perfo	psy pormed? d	Vere autopsy findings available rior to completion of cause of eath? Yes 2 No	
Vital Recysician: The his certificate director, page		25. Was case referred to medical examiner?			V1	26.Place	of Death (Check	k only one)	-		
of Vit ing Physici After this c uneral dire	2 L	1 🗸 Yes 2 No		npatient 2	ER/Outpatient			ing Home 5	Residence 6		
n of viding Ph		27. Manner of Death 1 Natural 5 Pen	ndina	, Day Year)	28b. Time of I	1 7	ry at Work? Yes 2 X No	unk	how injury occurre	eu	
Division o spital or Attending hours after death neral Director: After filled in by the fune	E S		estigation Fnd 3/	/ <u>25/2007</u> e of Injury - At h	Fnd 8:13 ome, farm, stree	am et, factory, office b			(Street and Number	er or Rural Route Number, City	
Div Hospital o 24 hours af Funeral D tely filled i	5	4 Homicide dete		found:	residence			8 Bhatr	y Ct. Wald	Acton Lane Apt A	
Division To the Hospital or Attenumithin 24 hours after death To the Funeral Director: completely filled in by the			Physician: To the bestaminer: On the basis of								
To the He within 24 To the Fu complete!		29b. Signature and/title of certifi	and manner s			29c. Licens				ed (Month, Day, Year)	
		Alle	W			O.C.	M.E.		March 26, 2	2007	
Jan		30. Name and address of person Susan Hogan MD.	n who completed caus Assistant Medic			n Street, Balt	timore, MD 2	1201	•		
Stat	te	31. Date filed (Month, Day, Year,	, s	egistrar's Signati							
Registra	11	111110		to Office any annual of the	-	~					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month EDGAR EUGENE PAGE March 18 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner Prince George's Doctor's Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09-26-1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Virginia 1 M 2 □ F 579-20-9703 82 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Directo Maryland Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5224 57th Avenue 20737 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give WW I I 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Completed by WWII Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Brick Mason Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Marion E. Page Florence Little 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin Stewart Page - Brother 7202 Adelphi Road, Hyattsville, MD 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 03/20/2007 4 Donation 5 Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Baltimore, MD 20781 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EMPHY SEMA **Physician** /Medical Due to (or as a consequence of): Examiner ACUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner P ESPITONY or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 7POTEMSION Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Wes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed this certificate funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Hapatient Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death **To the Funeral Director**: , сотрletely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 162810 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Abiodu Luck Rd. 8118 6cod 32. Registrar's Signature 31. Date filed (Month, Day

DHMH 17 Rev 1/2001

State

Registrar

MAR 22

			1 - For State Registrar	State of Ma	ıryland		artment rtificate			nd M		jiene _{og. No.} 20	07	A. III of the second	048
100	Physicia	an	Decedent's Name (First, Middle, La	ast) Made	line	Ε.	Parkei	r			2. Date of Dea Month March	19, 200	Year 17	3. Time of 8:30	
	/Medic Examin		4a. Facility Name (If not institution, gr	ve street and number)					ocation of	Death	TATOIT	4c. County		1 0.30	
	*		4319 Hartford H				lf I la day 1		land					eorge'	
	Funeral Director	Ď.		Sex 7. Age 1 M 2 1 F	67	ast birthday, Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Jan 14,	, Year)	9. Birth Cou Pen	place (State of ntry) nsylva	r Foreign nia
land	A ==		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or L	ocation							10d. Inside Cit	ty Limits
e Mary	a-f sh Uffied	ctor	Maryland Prince	e George's				Suit	land					1 ∑Yes	2 No
with th	B or 28	Funeral Director	10e. Street and Number 4319 Hartford H	Hills Drive			10f. Zip (^{Code} 207	116		1	Og. Citizen of		ntry?	
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ithin 7	nan "n Mad	Completed	(Specify only highest gi Elementary/Secondary (0-12)	College (1-4or 5-	+)		kind of work DO NOT use				ig				
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ad bla	Mental irked c	To Be	Alfred Co	nnors					N	Matt:	ie Conn	ors Bro	oks		
VICE Sho	h and 7 is mu		19a. Informant's Name/Relationship Gregory Parker	(Type, Print) (Son)							Route Number				
s tand	f Healt item 2 other	3	20a. Method of Disposition		20b. Pf	ace of Disp	osition (Nami	e of	- 1			20c. Location			
Page	ant: If ury or		1 ☐ Burial 2 🌠 Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec		1	sapeal	ke Cre	mato:	ry 3/			Beltsv			
permit	Departmentimportant: any injury once.		21. Signature of Funeral Service Lice	Laterniza	ر دا	2					imore F				P.A.
* 1	247 A		23a. Part 1. Enter the disease, or conshock, or heart failure. List onto	nclications that caused y one cause on each fin	the death	. Do not en							2010	Approximate Interval Bety	ween
	ysician Medical		Immediate Cause (Final disease or condition resulting in death)	. Cardic			heart	dise	ase					Onset and D	Death
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ate be e	physician and s the burial-transit	cal		d											
certific	nding p use as	√/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					-	·		23d. Da	te of deliv	erv	
UNISION OF VIGAL DECOLUS, F.C. BOX 00/00,	been signed by the attending pt should be detached for use as t	Physician/Med	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \) \(\subseteq \text{No} \)	1 ☐ Live birth :: 4 ☐ Pregnant at ! 9 ☐ Unknown			□Ectopic pre □ Other (spe					Мо	onth	Ďay Y	'ear
thatth	detach		9 ☐ Unknown Part II. Other significant conditions	contributing to death bu	ıt not resu	ılting in the u	underlying ca	use given	ı in Part I.		23e. Did to	bacco use con	ribute to	the cause of d	eath?
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e law	has be	Completed									24a. Was a autop: perfor	SV	Were autoprior to co	opsy findings a impletion of ca	available ause of
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hysici	his cer direct	ToB	examiner? 1⊠Yes 2□No	Hospital: 1 Inpatier		ER/Outpatie		A Other	4 □ Nurs		ne 5⁄2 Resid		er (Speci	fy)	
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r Atten	within 24 hours after death. To the Funare! Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	2 Accident investigation 3 Suicide 6 Could not determined	be Disease file	iry - At ho	me, farm, st					8f. Location (S City or Tow		oer or Rur	al Route Num	ber,
pitai o	aret Di		29a. Certifier 1 Certifying P	Physician: To the best of			th occurred a	it the time	date and	I place a	and due to the o	auco(e) and m	20001 35	ctated	
he Hos	n 24 hc he Fun oletely	Medical	(Check only 2 Medical Exa	iminer: On the basis of and manner sta	examinat	ion and/or ir	rvestigation,	in my opir	nion, death	h occurre	ed at the time, o	late and place,	and due	o the cause(s)
Tot	To the comp	Σ	29b. Signature and title of certifier	mot				License				9d. Date signe	/	/	
1 -	10		30. Name and address of person who	completed cause of de	eath (ftem	23a) (Tvoe		1003	1029	10 M	u	-5/	4	2007	
-(1	0		Deborah Thomps	on, M.D.	5100	Auth	Way,	Suit	land	MD 2	20746				
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** CUOPM MARRY J. PETERS 02 2 Z007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HOWARD TUNIARD COUNTY SON FRAZ HOSPITAL COLUMBIA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∑** M 2□ F Months 78 6/24/1928 Maryland Director 220 20 5401 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f shov notified at 1 ☐ Yes 2 No Funeral Director MD Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 6336 Cedar Lane #250 21044 USA death 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1X Yes 2 No Korean If Yes, Give Year or Dates Conflict 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify:White þ 3₺Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Electrical Engineer Government/Defense 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Harry Consul Peters Helen Scheck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any injury or other trau Lori S. Peters/daughter 12152 Jonathons Glen Way Herndon, VA 20170 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith 3/28/2007 Baltimore, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. MO1442 21. Signature of Funeral Service Licensee 4112 Old Columbia Pk. 21043 Ellicott City, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIC SINZK **Physician** 24425 /Medical Due to (or as a consequence of): Examiner 48 hes CirivuTIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4□Pregnant at time of death 5 Other (specify) P.O. as been signed by the a 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ MMY LES OSSIS 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No In numo suppression 24a. Was an has performed? certificate ha 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Hospital: 1 ☐ Copatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death. investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital c within 24 hours af To the Funeral D completely filled in 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1) 36974 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) 041 MECHAPIN CIVAL 10724 LITTLE PATURENT PARLWAY COWINGIA MANYLAMO 21074

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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ORIGINAL

egistrar's Signature

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

Examiner

Funeral

Director

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Director

Funeral

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Completed

Be

2

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

/Medical

burial-trar

Examiner

the attending physician and hed for use as the burial-trar Physician/Medical certificate has been signed by the attendin rector, page 2 should be detached for use þ Completed Be Certification: To After this within 24 hours after death To the Funeral Director: Medical

Division or Vital Records, P.O. Box 68760,

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide * Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29b. Signature and title of certifier

29c. License number

052323

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Opal 1126 CL

Hagerstown

State Registrar

31. Date filed (Month, Day,



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 2007 Pear **Physician** Beatrice Mae Puryear 1415 A ^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harrison Senior Living Snow Hill Worcester If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 🛛 F 364-03-5262 91 Director 12/20/1915 Michigan Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits al Hygene.
I other then "naturel", or iteme 23s or 28sm willownt, the Medical Evantaner must be motified at 1 ☐ Yes 2 No Director Worcester Berlin 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 38 North Pintail Drive 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritat Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White Completed by I If Yes, Give Year or Dates: 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant School System 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Deperment of Health and Mental Hy Important: If Item 27 is marked oth eny lipury or other treumatic eveni angle. Be George Stringer Emma Batzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lee Burnell Puryear 38 N. Pintail Drive, Berlin, MD 21811 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State Cape Henlopen Crem. 3/24/2007 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Euneral Service Licenses 108 William St., Berlin, MD 23a. Part1. Enter the disease, of shock, or heart failure. Lis Approximate Interval Between Onset and Death implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** oronaru /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physicien: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760. physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetat death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 Wo 3 Probably 4 □Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate 1 Yes 2 No After this certification 25. Was case referred to medical Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funerel C 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DARAD BARAL, MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 8 ocomoke Marke

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 22, 2007 **Physician** 8:30 Cynthia Ann Porter-Leeson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles 8430 Bensville Road Waldorf If Under 1 Year | If Under 24 Hrs. 8. Date of Birth NOV. 15 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) , 1942 Washington D.C. Days Hours 1□M 2XF Nov. 64 213-42-7279 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Maryland Charles Waldorf Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 8430 Bensville Road 20603 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Horse Breeder and College (1-4or 5+) Elementary/Secondary (0-12) Self employed Landscaping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amy Viola Shieble John Leo Shugard, Jr. ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sam Leeson/Husband 8430 Bensville Road, Waldorf, Maryland, 20603 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/25/2007 Waldorf, Maryland **Huntt Crematory** 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M01391 3035 Old Washington Rd. Huntt Funeral Home Waldorf, MD 20601 Approximate Interval Between Onset and Peath 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): EUMONI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusto (or as a consequence of) Examiner Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 3 DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 | Yes 2 | 1 | O 1 Inpatient 2 ER/Outpatient Medical Certification: To 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner

Funeral

Director

28a-f show

iral", or Items 23a or 28a-f shov Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or: any Injury or other traumatic event, the Medical Examiner must be n

Baltimore, Maryland 21215-0036

the Maryland

Division or Vital Records, P.O. Box 68760,

To the HospItal or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State

4 Homicide

29b. Signature and title

31 Date filed (Month, Day,

29a. Certifier

CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registres Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 12:10 PM Richards liam owers March 2007 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Chestertown
If Under 1 Year If Under 24 Hrs. Pointtalbot Heron Kent Wing 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) 08/09/1923 Birthplece (State or Foreign Country) Months Days Hours Min. 1**∑**M 2□F 232-24-8171 83 PA Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 218 HERON POINT 21620 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CHEMICAL ENGINEER ENGINEERING 4 17. Father's Name (First, Middle, Last) 18. Mother's Name /First, Middle, Maiden Surname FRANK ETHYLWULF POWERS LORAINE ELIZABETH RICHARDS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY POWERS/WIFE 218 HERON POINT, CHESERTOWN, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CHESAPEAKE CREMATORY 03/25/2007 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyneral Service Licensee Name and Address of Facility
LLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, PA
O SPEER ROAD, CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ ₩6 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 1 ☐ Yes 2 NO 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 20 No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and attending physicien Box 68760 use as the ţ ed by the a Records, P.O. has Division of Vital funeral director. this After death. ofter death Director: within 24 hours e To the Funeral I

Physician

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Examiner

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Physician /Medical

the Medical Examiner must be notified at

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Physician/Medical

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Certification:

Medical

29a. Certifier

(Check only one)

29b. Signature ar

with the Maryland

within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

U.CHAEZ 31. Date filed (Month, Day, Year)

title of certifie

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se of death (Item 23a) (Type, Print) E) Mon

32. Registrar's Signature

VERN RD SIES CORSSIERIAM, MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** ELSIE 13/3 PM G. PASE 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Peninsula Regional Medical Center Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 05/05/1933 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 → F 73 Director 213-44-2380 Maryland Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. n 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Delaware Sussex Seaford 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2705 Charles St 19973 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: white þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Norman Peppler Florence Landon ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau C. Edward Pase Jr. - son 518 N. Bradford St., Seaford, DE 19973 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State Spring Hill Memory Gdh.3/27/07 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cranston Funeral Home ature of Fun | Service Liou John A. Cranston P O Box 967, Seaford, DE 19973 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ADRIC **Physician** /Medical Due to (or as a consequence of): **Examiner** DISEASE WRAMARY Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) the attending physician 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No Month Year 4□Pregnant at time of death 5 Other (specify) Ö 9☐Unknown 9 Unknown cate has been signed by t page 2 should be detach ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 1 ☐ Yes 2 No 2□ No Division or Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Hopatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending 5 Pending investigation 1 Natural Iniurv 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29d. Date signed (Month, Day, Year) 29b. Signature itle of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Kurt

31. Date filed (Month Pay

Carroll

gistrar's Signature

6 2007

Salisbury MD

Registrar

State

Kevin M. Ford M.D.

NAR 1 9 2007

32. Registrar's Signature

7404 Executive Place #501 Lanham, Md. 20706

			· ·	and / Depa	artment of Health and M	•	6001	1056
	Discourse in the		Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		PETER PARENT RUCKER				29,2007	6:45AM
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
			7406 SHIRLEY BLVD. 5. Social Security Number 6. Sex 7. Age (In)	- land birds do N	PORT TOBACCO If Under 1 Year If Under 24 Hrs.	O Date of Dimb	CHARLI	
	Funeral Director		375-28-4382 Usual Rasidence of Decedent	yrs. last birthday) Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye MAY 1 1	925 MICH	place (State or Foreign ntry) HIGAN
	death with the Maryland ims 23e or 28e-f show rights be notified at			. City, Town or Lo	cation		1	10d. Inside City Limits
	the Marylar 28e-f show	to	MARYLAND CHARLES	PORT TO	DBACCO			1 ☐ Yes ANO
	h the	Directo	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Coul	ntry?
	15 will		7406 SHIRLEY BLVD.		20677		U.S.A.	
	ems	iner	11. Marital Status 12. Was Decedent Ever Armed Forces?	n U.S. 13.	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
98	or It	by Funeral	1 ☐ Never Married 2 ☑ Married 1 ☐ Ves 2 ☐ No		1 ☐ Yes 2 🕱 No Specify:		Canaitu	
5-0036	72 hours after neturel', or Ite		3 Wildowed 4 Divorced Year or Dates: WW	II		1	MIT	
75	"net	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of workir DO NOT use retired)	101	. Kind of Business/In	
2121	within ene. then	mc	Elementary/Secondary (0-12) College (1-4or 5+)			DU		CHARLES
	filed Hygid other ent.	0	12 17. Father's Name (First, Middle, Last)	EAECC	JTIVE VICE PRES	(First, Middle, Maid	den Sumame)	LUMBER
<u>a</u>	Mental Mental arked o	To B	LOUIS RUCKER		MARIE E	OBERTS		
Maryland	2 shou and M Is mar eumet	_	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or Rura		ty or Town, State, Zip	Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Maralal Hygiens I mortener; if item 27 Is marked other then "neturel", or Items 23e or 28e-f show may injury or other treumetic event. It a Medical Examination must be notified at any injury or other treumetic event.		IVA D. RUCKER-SPOUSE	7406	SHIRLEY BLVD.	PORT TO	BACCO. N	ID 20677
J. C.	es 1 a of He fitem		20a. Method of Disposition	b. Place of Dispo	sition (Name of Dinatory or other place)	ate 20c	BACCU N Location - City or To	own, State
E	Page nent c int: if		XXBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MAR	-	ETERANS CEM. 4-	-3-07 CH	ELTENHAM	I MD
Baltimore,	permit. Page Department Importent: fi any injury or once.			00479 22	. Name and Address of Facility			.,
m	89889		Muchal Kan	J T	RAYMOND FUNERAL	SERVICE	P.A.	
			23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one dishock on each line.	leath. D	er the mode of dying, such as carplac o	respiratory arrest,	0	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	u C	once.		0	Onset and Death
	/Medical		resulting in death) Due to (or as a con					
	Examiner		Sequentially list conditions					
2	p ii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ecquanes of):				
2.	and and rtrans	каш	that initiated events c. resulting in death) Last C. Due to (or as a con	secuence of):				
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	e y e		d			****		
×	certif ding ise as	/Me	IF FEMALE: 23c. If yes, outcome of pre	egnancy			23d. Date of deliv	env
Вох	atter I for u	ciar	in the past 12 months?	Fetal death 3	Ectopic pregnancy Other (specify)		Month	Day Year
o.	the d y the sched	ysi	1 Yes 2 No 9 Unknown 9 Unknown					
σ.	w requires that the death been signed by the atte should be detached for	y P	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to t	he cause of death?
rds	quires n sign uld be	d be				1 ☐ Yes	2□No 3□Prot	pably 4 hknown
Records,	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as th	Completed by Physician/Med				24a. Was an	24b. Were auto	opsy findings available
Re	ding Physicien: The lav h. After this certificate has funeral director, page 2	шо				autopsy	l? death?	mpletion of cause of
	en:] tifical tor. p	a)	25. Was case referred to medical		26. Place of Death	(Check only one)	NO ILITES	2 140
>	Physicien: this certificatal director.	To B	examiner? 1 ☐ Yes 2 ☐ 10 Hospital: 1 ☐ Inpatient	2 ER/Outpatien	Othon		e 6 ☐Other (Specia	fv)
	g Phy er thi		27. Manner of Death 28a. Date of Injury			8d. D scribe how in		,,
<u>o</u>	Attending r death. sctor: After by the funer	atlo	1. Natural 5 ☐ Pending (Month, Day Fea 2 ☐ Accident investigation	(r) Injury	M 1 Yes 2 No			
Division	Atte	ific	3 Suicide 6 Could not be determined 28e. Place of Injury - building, etc. (Sp.	At home, farm, str	eet, factory, office	8f. Location (Street City or Town, St	t and Number or Rura	al Route Number,
Ö	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	building, 615. (Sp	00.177		ony or rown, o		
	hour hour uner	cal	29a. Certifier 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam					
	the H nin 24 the F the F	Medical	one) and manner stated.					
	5 美 6 8	2	29b. Signature and title of certifier	A	29c. License number		Date signed (Month,	Day, Year)
			* Koule Mal		1) 5 8 2 2	7	5/2-9/	07
	5H		30. Name and address of person who completed cause of death	Item 23a) (Type,	D2835	1	0 1	0011
			31. Date filed (Month, Day, Year) 32. Registrar's S	ionature	1 1	` ` `	D of	0640
*	Sta Registr		52. negistrars S	As A	(ach)			
139	3,0	19	APR U D ZUU/ A CONTRACTOR	130				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2007 March 22, 10:58 P M Burton Carlin Rush 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Casey House Rockville 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 17, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) New York 89 Months Days Hours 1**X** M 2 □ F 1917 085-05-0329 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1√2 Yes 2 □ No Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 401 Russell Avenue #413 20877 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify:White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Graphics Design Business Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rose Carlin Jacob Rush 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6917 Maple Avenue Chevy Chase, MD 20815 Barney Rush/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Chesapeake Crematory 03/24/07 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Syndrome Due to (or as a consequence of): Methicillin Resistant Staphylococcus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Valvular Heart Disease Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown

Physician /Medical Examiner

the attending physician

this After

4 hours after death. filled in by

within 24 hours a To the Funeral C

artment of Health and Mental Hyg ortant: If item 27 is marked other injury or other traumatic event, i

permit. Page Department o Important: If a

Physician

/Medical

Examiner

Funeral

Director

show

'natural", or items 23a or 28a-f shov dical Examiner must be notified at

Director

Funeral

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Completed

Be

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MD

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

burial-trar the Examiner

Physician/Medical

<u>\$</u>

Completed

Be

Certification: To

29b. Signature and title of certifier

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Part II. Other significar	it conditions c	ontributing to death but not res	uiting in the underlying	g cause g	iven in Part 1.			se contribute to the c			
							1 ☐ Yes 2 🔀	No 3 ☐ Probabl	y 4 Unknown		
							24a. Was an autopsy performed? 1∐ Yes ≱∏ No	death?	findings available etion of cause of		
25. Was case referred	to medical				26. Place of De	eath (0	Check only one)				
examiner? 1 ☐ Yes 🏖 No		Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	Home	e 5 ☐ Residence 6	XOther (Specify)	hospice				
27. Manner of Death 1 Natural 5 2 Accident	☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M		uryat ork? ∐Yes 2∐No	286	28d. Describe how injury occurred				
3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					f. Location (Street and City or Town, State)		oute Number,		
		ysician: To the best of my knoniner: On the basis of examina									

29c. License number

H0058032

29d. Date signed (Month, Day, Year)

(b)02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia M. Williams, D.O 6001 Muncaster Mill Rd. Rockville, MD 20855

State Registrar

32. Restrar's Signature 31. Date filed (Month, Day, Year) MAR 2

nthis m. Williams DO

Physicia /Medica Examine

Funeral Director

	State Registrar				C	ert	ificat	e of L	Death			Reg. 1	vo. 🤈	DO:	7	-	05
	1. Decedent's Name	e (First, Middle	e, Last)								2. Date of D Month	eath [Day	_ Year	3.	Time of I	Death
in al	Elmer Eug	ene Rus	se, Jr.								March					7:55	Рм
er	4a. Facility Name (If Casey Hou	se	n, give street and nu]	Rock	vill]		ty of Deat	rу		
	5. Social Security N 216-64-72	43	6. Sex 1 X M 2 ☐ F	7. Age (In ye	s. last birthd		If Under Months		If Under Hours	B. 81	8. Date of B (Month, D Sept 8	irth lay, Yea	954	9. Birt Co Mary	hplace ountry) y Lai	(State or nd	Foreign
	Usual Residence of 10a. State	10b. County		10c.	City, Town or	r Loca	ation								10d. 1	Inside City	y Limits
ctor	Maryland	Montgo	omery	Ga	ithers	bu						10	1 Yes 2 No g. Citizen of What Country?			2 □ No	
al Dire	10e. Street and Nur 8120 Chel		Court				10f. Zip 208	79	USA								
by Funeral Director	11. Marital Status 1 □ Never Marri 3 □ Widowed		cedent Ever in orces? 2 ☐ No ive Dates: 197	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						BI	4. Race - American Indian, Black, White, etc. Specify: White						
ed		15. Deceden	t's Education		16a. De	ecede	nt's Usu	al Occupa	ation			16b.	Kind of	Business/	Indust	гу	
Completed	(Speci		st grade completed, College) (1-4or 5+)			ind of wo O NOT us Driv		during mo: 1)	st of workii	ng	Tr	ucki	ng Co	ompa	any	
Ŭ	17. Father's Name ((First, Middle,	Last)						18. Moth	er's Name	(First, Middl	e, Maio	len Surna	ame)			
lo Be	Elmer Eug	ene Ru	se, Sr.]	Mary	Ann	Crone						
-	19a, Informant's Na	ame/Relations	hip (Type. Print)		19b. M	lailing	Address	(Street	and Numb	er or Rura	I Route Num	ber, Cit	y or Tow	n, State, 2	Zip Co	de)	
	Randolph	Willia:	m Ruse/br						ry Ct		ithers	_					
	20a. Method of Disp 1 ☐ Burial 2 I 4 ☐ Donation	Cremation	3 □Removal from	State	n. Place of Di cemetery, hesape	crema	atory or c	other plac	ory		^{0ate} 4/07			i - City or			
	21. Signature of Fu	wend	Litter			Be	ver1	y L.	Hecl	krott	n Serv e, P.A	<u>. C</u>			le,	MD 2	21029
	23a. Part1. Enter to shock, or hea	he diseas€, or art failure. List	complications that only one cause on	caused the de each line.	eath. Do not	ente	r the mod	le of dyin	ng, such a	s cardiac c	r respiratory	arrest,			Int	proximate erval Betv set and D	veen
	Immediate Cause (disease or conditio		a.Lung	Cancer											OI OI	iset and L	realli
resulting in death) Due to (or as a consequence of):																	
_	Sequentially list co if any, leading to in	nditions,	b	/01.00.0.000	aguanaa af\												
Wedical Examiner	cause Enter Inde	riving	Due to	o (or as a cons	equence or):												
-	Cause (Disease or that initiated events resulting in death) I	Last	c	o (or as a cons	sequence of):	:											
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200													T				
be completed by higheralizing	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2[9 ☐ Unknown	months?	1 ☐ Live	utcome pf pre birth 2□F gnant at time o nown	etal death		Ectopic p Other <i>(</i> s <i>j</i>		/					Date of de Month	livery Da	y Y	'ear
	Part II. Other signi	ficant conditi	ons contributing to	death but not	resulting in th	ne und	derlying	ause giv	en in Part	l.	23e. Dio	l tobaco	co use co	ntribute t	o the c	ause of d	eath?
2											¹X̄	Yes	2 □ No	3 □ P	robabl	y 4 □L	Inknown
											pei	opsy formed	?	prior to death?	comple	findings a	available ause of
5	25. Was case refer	rred to medica	1						26 Plac	re of Death	1 ☐ Yes		No	1 □ Yes	3 2L	No	
	examiner? 1 □ Yes 2∑		Hoopital	Inpatient 2	ER/Outpa	atient	3 🗆 D	Oth			me 5□Re		e 6 □ Xc	Other (Spe	ecify) 1	nospi	ce
	27. Manner of Deal	th 5 Pendir investi	28a. Date	e of Injury onth, Day Year	28b. Tin		М	28c. Injur Wor			28d. Describ						
er mice	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could detern	singe Zoe. Fide	ce of injury - A ding, etc. (Sp	t home, farm	n, stre	et, factor	y, office			28f. Location City or T			mber or R	tural R	oute Num	ber,
Medical Certification:	29a. Certifier (Check only one)		ng Physician: To the Examiner: On the and ma)
ME	29b. Signature and	title of certified	m Dul	lear	no Di)			se number 580			29d.	Date sig	ned (Mon	th, Day	, Year) 200	7
	30. Name and add		who completed ca					 	Rd. I	Rocky	ille.						-
	31. Date filed (Mor			egistrar's Si		. J L	UL 11			LOCKV							
te ar		MAR 2		Leen		do	Bell.	,									

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death March Physician Steven 12:11 A M Rosenthal 28 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 45547 Stoney Run Drive USA Great Mills If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) October 7, 19 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 063-38-2572 11X M 2 □ F 61 Director 1945 New York Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2本 No Maryland St. Mary's Great Mills Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45547 Stoney Run Drive USA 20634 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. Specify 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry within 72 h (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Engineer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Abe Rosenthal Fannie Zukowsky ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45547 Stoney Run Drive Great Mills, MD 20634 Linda Rosenthal / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State April 1. United Hebrew Cemetery Staten Island, New York 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part I Enter the disease, or compil ations that caused the death. shoct, or heart failure. List only one cause and line. Immediate cause (Final disease or condition regulation) Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, MD Approximate Interval Between Onset and Death o not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Lines of inderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a ☐Yes 2☐No 9□Unknown 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed es 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No al or Attend after death. 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division

State Registrar

Dr. Jennifer Mamidt, 40900 Merchants Lane, Suite 205, Leonardtown, Maryland 20650 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of

32. Registrar's Signature

son who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

			State of Maryland / Department / Depart		lental Hygie	ene	11000		
		8	Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg 2. Date of Death	J. No. UU /	3. Time of Death		
	Physici		Robert Rolland Ridenour		Month	Day Year			
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	March 2	23,2007 4c. County of Dear	10:25 A M		
	*	£.	Ravenwood Luthern Village	Hagerstown		Washington			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,)	9 Birt	hplace (State or Foreign		
	Director		Usual Residence of Decedent		June 4 1		ryĺand		
fand	at ow		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits		
Mary	a-f sh ffled	ţċ	Maryland Washington Hager	rstown			1 X Yes 2 □ No		
th the	or 28a e noti	Directo	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Co	ountry?		
ith wi	23a c ust be		201 Chartridge Drive	21742		USA			
er dea	tems er m	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit			
d 21215-0036 flied within 72 hours after death with the Maryland	nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	by F	1 □ Never Married 2 □ Married 1 📉 Yes 2 🗆 No	1 ☐ Yes 2 🔯 No Specify:		Specify:	White		
Maryland 21215-0036 d 2 should be filed within 72 hours af	atura cal E	ted	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16	6b. Kind of Business/	Industry		
215	e. an "n Medi	Completed	(Specify only highest grade completed) (Give	kind of work done during most of worki DO NOT use retired)	ing		,		
Z with	/gien er tha t, the	S	12 0 Lie	eutenant	<u> </u>	Correct	ions		
ind be file	lental Hy ked oth ic eveni	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	iden Surname)			
aryla	d Men narke natic	은	Lester T. Ridenour		erne Lak				
Man d2st	ar is		i l	ng Address (Street and Number or Rura					
6, 7		11 9		Sition (Name of natory or other place)		ing, Md. 2			
mor Pages	Department of Heal Important: If item 2 any injury or other once.		A Daniel 2 Document of Themoval from State			·	,		
Baltimore,	ortan injur		Rese Have	en Cemetery 3/27 2. Name and Address of Facility Min	/07 Ha	gerstown,	Maryland		
Balt permit.	a m b c			.5 E. Wilson Blvd.		neral Home			
dir.			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac of	or respiratory arres	t,	Approximate Interval Between		
Ph	ysician		Immediate Cause (Final disease or condition Multi-while Immediate Cause (Final disease or condition Immediate (Final disease or condition	dementia			Onset and Death		
	Medical aminer		resulting in death) Due to (or as a consequence of):	V					
EX	ammer	_	f any, leading to immediate Due to (or as a consequence of):	lation					
ped	ısit	Examine	Equantially fist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated expents.)	men monte					
, xecu	al-trar	xan	that initiated events resulting in death) Last c. Due to (or as a consequence of):	meamours Aysfurction					
ate be	g physician and as the burial-transit	dical	Swallowing	dysfunction					
ox 68/60, certificate be executed	ig phy as the	ledio	- U						
ath cer	endin r use	N/ue	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□Fetal death 3□	Ectopic pregnancy		23d. Date of del	ivery		
the death	certificate has been signed by the attending prector, page 2 should be detached for use as	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year		
	d by t etach	Phy	9 Unknown						
OrdS, F	signe I be d	by	Part II. Other significant conditions contributing to death but not resulting in the un	idenying cause given in Part I.	1	cco use contribute to			
	been	etec	Harris Legan in		1 □ Yes	2 X No 3 ☐ Pr	- 4 DONKHOWN		
d) (C	ge 2 s	Completed	Maria Maria		24a. Was an autopsy performe	prior to c	topsy findings available completion of cause of		
VITAI ician: Th	ificate or, pa		25. Was case referred to medical		1 Yes 2 5	No 1 Yes	No		
/sicia	s cert	o Be	examiner? 1 Yes Yes	26. Place of Death		ce 6 Other (Spec	-7.1		
g Phy	er thi	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how		ory)		
SION	ath.	atio	Natural 5 ☐ Pending (Month, Day Year) Injury	M 1 ☐ Yes 2 ☐ No					
Y Affe	recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street building, etc. (Specify)	et, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,		
اً <u>ت</u> ا 5	rs an	Çe	Va						
Hosp	Within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) Medical Examiner: On the best of my knowledge, death of the best o	i occurred at the time, date and place, a vestigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)		
o the	o the	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month	Day Year)		
F 3	s ⊢ ŏ		And Amo.		1	march	23,2007		
		}	30. Name and address of person who completed cause of death (Item 23a) (Type, I	Print)	,	0000	11		
5/+.	3+1		JERRY L. COPPECES, M.D.	Print) thy opel co.	urt, G	traferstow	n, mD		
8,	Sta	te	31. Date filed (Month, Day, Year) 32. Pigistrar's Sighature	1. 18 1	()		27740		
	Registra	ar	MAR 27 2007						

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	ryland	-	artment rtificate			ind Me		giene Reg. No.	2007	11061
ť	Physici		1. Decedent's Name (First, Middle, L	ast) NCE F		RI	タレバンノ	ole	15		2. Date of De Month	ath Day	2007	3. Time of Death 10:27 PM
	/Medic Examin		4a. Facility Name (If not institution, g Montgomery Gene	ive street and number)	1		4b. City, To		Location of	f Death			ounty of Death ntgomer	
	Funeral Director		191–14–7064	Sex 7. Age 1X M 2□ F	(In yrs. I	ast birthday) Yrs.	If Under 1 Months I	Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da Dec • 6	, 1925	9. Birth Cou Dela	place (State or Foreign Intry) Ware
	Maryland f show led at	or	Usual Residence of Decedent 10a. State 10b. County Maryland Montgom	ery		, Town or Lo								10d. Inside City Limits 1 XYes 2 □ No
	with the Na or 28a- st be notified	I Director	10e. Street and Number 3227 Bel Pre Roa	d.			10f. Zip C	ode 2090	6				en of What Cou	•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notitiled at ance.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Midowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 □ N If Yes, Give W Year or Dates.	lo		Was Deceder If Yes, specify	-	spanic Origin, Mexican	gin? (Spec , Puerto F	city Yes or No Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
21215-0036	To the part of the						g		d of Business/li Ltary	ndustry				
Maryland 2	uld be filed Aental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, La Paul Frederick F		<u> </u>				_		(First, Middle L. Shu		Gurname)	
2	1 and 2 short Health and Meem 27 is ma		19a. Informant's Name/Relationship John Ravilious/S			15131	Deer	Val	ley :	Terra	ce,Sil		Town, State, Zi Spring, I	ip Code) MD 20906
altimore,	Pages 1 annument of He ant: If item ury or other	,	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☒ Donation 5 ☐ Other (Special Content of the Content		Geo Med	lace of Dispo emetery crei prgetov lical (sition (Name matory or oth M Univ Lenter	of er place V er s	ity N	March 200	ate 1 20 17	Wash	ation - City or T nington	,D.C.
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lic	Sunda		22	2. Name and	Addres	s of Facility	yColu	mbia M	ortua , D.C	ry Serv 2003	vices,Inc. 7
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that caused ly one cause on each lin a	e. VTh	miA	er the mode	of dying	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
ă.	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. COR	c N A	Proceeds:	ARTO	Ry	Di	SEL	ISE			months
,092	ate be executed hysician and the burial-transit	ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Atherosclerotic Disease Due to (or as a consequence of):									YEARS	
Records, P.O. Box 687	Attending Physician: The law requires that the death certificate be executed rideath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Ves 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy Month										very Day Year	
rds, P	quires that n signed b uld be deta	by	Part II. Other significant conditions	s contributing to death bu	ıt not resu	ulting in the u	nderlying cau	ise give	n in Part I.		23e. Did 1		1	the cause of death?
I Reco	The law rec cate has been page 2 shou	Completed									24a. Was auto perfe 1 Yes	psy ormed?	24b. Were aur prior to c death? 1 ☐ Yes	topsy findings available ompletion of cause of 2 No
Z Z	siclan: Th certificate irector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2 EP	ER/Outpatier	nt 3∏ DOA	Othe	r .		(Check only		☐Other (Spec	36.1
Division or Vital	nding Physiclan: th. :: After this certific e funeral director,	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injui (Month, Day	y	28b. Time o Injury		c. Injury Work		2	8d. Describe			nry)
The part of the pa								2		Street and wn, State)	Number or Ru	ral Route Number,		
	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in by	Medical C		Physician: To the best of aminer: On the basis of and manner sta	examina									
)	To the l	M	29b. Signature and title of certifier	f. La	kin	im	29c.		number	981	15		signed (Month	2007
			30. Name and address of person where Robert F. I					ince	Phi]	lip D	r. Oln	ey.MI	20832	
	Sta Regista		31. Date filed (Month, Day, Year) MAR 2 2	32. gistra	ar's Signa		4					4 1		
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DHMH 17 Rev 1/2001

07-02289 Mary Jo Ray-L	ane	Please Type or Print State of Mary	land / Depart	tment of	f Health ar			egible.	07 1100
Dhusi		Registrar 1. Decedent's Name (First, Middle,Last)	Certi	ficate of	Death		2. Date of D	Reg. No.	3. Time of Death
Physic Medical Exan		Mary Jo Ray-Lane					Month March 2	Day Year	0951 hrs
		4a. Facility Name (if not institution, give street and	number)		4b. City, Town, o	r Location of		4c. County of	Death
		Johns Hopkins Hospital			Baltimore (City			
Funera Directo		5. Social Security Number 6. Sex	7. Age (In yrs. last		If Under 1 Ye		Min	` 1	Birthplace (State or Foreign
Directo	1	554-37-5051 1 M 2XF	41	0 Yrs			2/9/	1967	Country) NY
iny		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Locat	ion	_		<u> </u>	10d Inside City Limits
br how i		MD	Balt:	imore					1 X Yes 2 No
death with the Maryland or items 23a or 28a-f show any	Director	10e. Street and Number			10f. Zip Code		10g. Citizen of Wha	t Country?	
the N	ă	218 Wolfe St. South			212	231		US	A
h with	Funeral		ecedent Ever in U.S. Forces?				n? (Specify Yes or I	No- 14. Race - White,	American Indian, Black, etc.
r deat	Ξ	1 Yes	2 X No				dente / medin, etc./		
rs afte ural",	ģ	3 Widowed 4 Divorced If Yes, Give Y or Dates: 15. Decedent's Education (Specify only highest gr		1	Yes 2XX No		nd of work done	Specify: 16b. Kind of Busi	White ness/Industry
72 hou	eted		(1-4 or 5+)		ost of working life			1,42,1,11,1	,
215-0036 be filed within 7 ntal Hygiene. rked other than	Completed	9	I	Homema	ker			Own Home	е
5-0 iled w Hygie	ပိ	17. Father's Name (First, Middle, Last)				18.Mother's	Name (First, Middle	e, Maiden Surname)	
							e Decesar		Chata Tia Cada
MD 21 ad 2 should lith and Me m 27 is ma	۱ř	Louis Lane Father		- '			,CA 90024		
and 2 lealth tem 2		20a. Method of Disposition		ace of Dispos	sition (Name of ce		Date Date		City or Town, State
DOFE ages nt of F		1 Burial 2 X Cremation 3 Removal	HOIH State	ematory or ot	herplace) matory		4/3/2007	Baltimore	, MD
Baltimore, permit. Pages I ar Department of Hee Important. It ite		4 Donation 5 Other Specify: 21. Signature of Fureral Service/Licensee	11001					Funeral HO	
Dep Dep		Gaty (1)		12	Ridgely	Ave.	Annapoli	s. MD 2140)1
Physicia		23a. Part I. Enter the disease, or complications that failure. List only one cause on each line	caused the death. D	o not enter t	he mode of dying	, such as car	diac or respiratory	arrest, shock, or hear	t Approximate Interval Between Onset and
Examine	•	Immediate Cause (Final disease a. Methad	one intoxica	ntion co	molicatin	athero	osclrotic ca	ardiovascula	r Death
			a consequence of):	01Seas	æ				
	ĕ		a consequence of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	a consequence of):						
	EX	events resulting in death) Last Due to (or as d.	a consequence or).						
executed ian and trans	sician/Medical		PII,27,28a-f	- porME	1 a867 5/	ייי דיי	r		
760, cate be	Med	IF FEMALE: 23c. If yes	s, outcome of pregna	ancy	1,g001, 3/		L	23d. Date of d	elivery
68 certifi	ian	past 12 months?	e birth gnant at time of deat	<u>_</u>	etal death 3	Ectopic	pregnancy	Month	Day Year
30X death	ysic	1 Van 2 No Cal Halmann	known	2 0	ther (Specify)				
Division of Vital Records, P.O. Box 68760, ral or Attending Physician: The law requires that the death certificate be as after death. 31 Director: After this certificate has been signed by the attending physici or the control of the state of the build he decoded for most the build he decoded.	/ Phys	Part II. Other significant conditions contributing	to death but not res	ulting in the	underlying cause	given in Part	11. 23e. Did		ute to the cause of death?
ires th	d by	Interstitial nephriti	s				1 `	/es 2 No 3	Probably 4 V Unknown
ords v reques	ompleted							opsy pri	ere autopsy findings available for to completion of cause of
Pecc	i i		<u> </u>			_			ath? ✓ Yes 2 No
al R	e C	25. Was case referred to medical			26.Plac		Check only one)		
Vit hysici this c	To B	examiner? 1 ✓ Yes 2 No Hospital: 1	Inpatient 2 🗸 E	· · · · · · · · · · · · · · · · · · ·			Nursing Home 5	Residence 6	Other:
ling P	Ë	1 Notural (Mo	te of Injury nth, Day,Year)	28b. Time of		ury at Work? Yes 2 🏋 I	1	e how injury occurre	d
Sior Attended	catic	2 Accident Investigation	3/25/2007 ace of Injury - At hom	unk				(Street and Number	or Rural Route Number, City
Div.	Certification:	Suicide Setermined (Special	by House	ne, raim, sire	et, ractory, office	building, etc.			Altimore, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death. To the Function: After this certificate has been signed by the attending physician and	September	29a. Certifier 1 Certifying Physician: To the b	est of my knowledge	e, death occu	rred at the time.	date and plac	ce, and due to the ca	use(s) and manner a	as stated.
thin 24	Medical	(Check only one) 1 Certifying Physician: To the base and manne	is of examination and	d/or investiga	ation, in my opinio	on, death occ	urred at the time, da	ite and place, and du	e to the cause(s)
	ĕ ĕ	29b. Signature and title of certifier	, Junou.		29c. Licer	ise number			d (Month, Day, Year)
		(1,51)			1 00	.M.E.		March 26, 2	007

State Registrar

Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day, Year) APR 0 3 2007

07-02292 Ralph E. Rea. Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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vaipii L. Ivea, or.		For State Crivial yield / Department - For State		Reg.	No.	1 1100
Physicia	n/	legistrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month	av Year	3. Time of Death 1022 hrs
Medical Examin		RALPH EDWARD REA JR	4b. City, Town, or Location of	March 25, 2	007 4c. County of Death	
		4a. Facility Name (if not institution, give street and number) Chester River Hospital Center	Chestertown	Death	Kent	
Funeral	7	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)			15	thplace (State or
Director	1	$216-17-0192$ $_{1}X_{M}$ $_{2}_{F}$ 24	Yrs. Months Days Hours	Min. 05/05/		untry) MD
é	F	Usual Residence of Decedent 10c. City, Town or Lo 10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
ne Maryland or 28a-f show any fied at once.	١		ERSVILLE			1 Yes 2 X No
darylar 28a-f s	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	ntry?
h the N		5504 SUDLERSVILLE ROAD	21668		USA	ican Indian, Black,
ath wii items ?	Funeral	1 X Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican,		White, etc.	ican indian, black,
fter de		1 Yes 2 No 3 Widowed 4 Divorced of Pates 1	Yes 2 X No specify:		Specify: WHI	ΓE
nours a	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedering	dent's Usual Occupation (Give ki g most of working life. DO NOT u		6b. Kind of Business/	Industry
36 nin 72 e. than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 9 N/A	- UE			
5-00 ed with tygien other	녌	17. Father's Name (First, Middle, Last)		Name (First, Middle, Ma		
21215-0036 ould be filed within 7 Mental Hygiene, marked other than it event, the Medica	Be	RALPH EDWARD REA, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Numb	EDNA MARIE I		Zin Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho- injury or other traumatic event, the Medical Examiner must be notified at once.	의		04 SUDLERSVILLE			
Fe, N I and Health Fitem	Ì		position (Name of cemetery, r other place)	Date	20c. Location - City or	Town, State
Pages nent of ant: I		4 Donation 5 Other Specify:		03/31/2007		
Baltimore, permit Pages I ar Department of He Important: If ite		21. Signature of Funeral Service Licepsee	2. Name and Address of Facility FELLOWS, HELFEN 130 SPEER ROAD,	NBEIN AND NE	EWNAM FUNE	RAL HOME, PA
Physician	\dashv	23a. Part I. Enter the disease, or complications that caused the death. Do not ent	er the mode of dying, such as ca	rdiac or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Cardiac arrhythmia				Death
LXaIIIIICI		or condition resulting in death) Due to (or as a consequence of): Cardiomegaly				
	Ę	if any, leading to immediate Due to (or as a consequence of):				
	Examiner	cause. Exter Underlying Cause (Disease or injury that initiated events resulting in death) Last used to (or as a consequence of):				
760, foate be executed physician and the burial - transit		d				
O, be exe	Medical	X UNPENDED AMENDED +,PII,27,perME,	g866, 4/10/07 TT		23d. Date of deliver	
8760, tificate bug physicas the bug		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic	pregnancy		Day Year
Box 687 ne death certific the attending p	sician	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			
O. B. trhe de by the	Phy	Part II. Other significant conditions contributing to death but not resulting in the	the underlying cause given in Pa		acco use contribute to	
ires that the signed by signed by I be detach	d by	Cocaine use				bbably 4 Unknown
ords v requi	Completed			24a. Was ar autops	y prior to	utopsy findings available completion of cause of
RecC The lav	mo			perform 1 ✓ Yes 2		res 2 No
Vital F ysician: his certifi director,	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpa	26.Place of Death tient 3 DOA Other		Residence 6 Other	er:
of Vital Records ing Physician: The law required After this certificate has been uneral director, page 2 should	.T	1 V Yes 2 No Impatient 2 Livodipal 27 Manner of Death 28a. Date of Injury 28b. Time	tion o bort	,	ow injury occurred	
OD C ending sath. or: Af the fun	tion	1. Natural 5 Pending 2 Accident Investigation	1 Yes 2			
Division of Vital Records, tal or Attending Physician: The law require rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	street, factory, office building, et	c. 28f. Location (St or Town, St		Rural Route Number, City
ospital hours : nneral y filled	Se	4 Homicide determined (Specify) 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death of	accurred at the time, date and pla	ace, and due to the cause	e(s) and manner as sta	ated.
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigated. and manper stated.	stigation, in my opinion, death oc	curred at the time, date a	and place, and due to	the cause(s)
To To COI	Me	29b. Signature and title of certifier/	29c. License number		29d. Date signed (M	
		XICUTION	O.C.M.E.		March 26, 2007	
		30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111	Penn Street, Baltimore, I	MD 21201		
S	tate	22 Pogistary Signature			<u> </u>	
Reais		MAR 3 0 2007				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** LEILA HENRIETTA SKINNER 3-30-2007 5:30A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CHAS.CO.NUR.& REHAB. CENTER LA PLATA CHARLES 8. Date of Birth (Month, Day, Year) 9. Birth (Co. 2) 12-26-1922 MD. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🔽 F Director 220-16-9157 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminer must be notified at anone. 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MD. CHARLES LA PLATA **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10200 LA PLATA ROAD 20646 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify: WHITE If Yes, Give Year or Dates: 3 □ Vidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be STEVEN CARD MARY GARNER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAT McLAUGHLIN-DAUGHTER 715 PYSELL CROSSCUT RD. OAKLAND, MD. 21550 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) ST.IGNATIUS CEM. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-2-2007 | HILLTOP, MD. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee MOO479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Years /Medical Years **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner iptital or Attending Physician: The law requires that the death certificate be executed using after death. Peral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Dementia, Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Myputhyroldism 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 12 No 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours af To the Funeral D completely filled in 1 💢 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

4

Registrar

Pembrooke Square 31. Date filed (Month. Day, Year) APR 0 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11350

32. Registrar's Signature

R. Sinddewal

D 61666

R. Sindhwazi MD

March 30 th, 2007

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7

				Otato of Ma	yiana / L	Certi	ificate of	Death		Reg. No.	07	1108	55
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4	Physici /Medio		James Martin Shay							17, 200		2:30am	
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	eath v	Funeral Director	1311 Ray Road	2. Was Decedent Ev	ver in U.S.	13. Wa	207 as Decedent of		pecify Yes or N	United :	e - American		
020	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Merylend Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at an once.		1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced		es, specify Cu Yes 2√∑ No	Hispenic Origin? (Suben, Mexican, Puert Specify:	o Rican, etc.)	Black, White, etc. Specify: Black					
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Division of Vital Records, P.O. Box 68760 soptial or Attending Physician: The law requires that the death certificate b hours after death. Ineral Director: After this certificate has been signed by the attending physical properties of the funeral director, page 2 should be detached for use as the bu	Certification:		termined (Spe	ecify) Sing	gle Family				67	or Towr 00 96th,	n, State) Lanham	, Md.		
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To the Hos within 24 h To the Fur	Medical	one) 2 Medical Ex	caminer: On the b	asis of exam	nination and/or	investigation	n, in my opıni	on, death oc	ccurred at the	ne time, da	ate and pl	ace, and c	due to the ca	
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State 31. Date filed (Month, Day, Year)
Registrar MAR 2 3 2007

30. Name and address of person who completed cause of death (Item 23a)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month O3 **Physician** 2007 8:30 AM SPARROW DONALD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner SANDY SPRING MD MONTGOMERY BROOKE GROVE NURSING HOME If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1**X** M 2□ F Aug. 17, 1921 Washington, D.C Yrs. 579-14-0389 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐XNo Maryland Directo Montgomery 01ney 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20832 U.S.A. 4112 Charley Forest Street Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1XIYes 2□No WWII If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White altimore, Maryland 21215-0020 þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cartographer Army Map Service 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Francis Heflin Clifford Vernon Sparrow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10609 Budsman Terrace, Damascus, Maryland 20872 Susan Petrich / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Method of Disposition 1 Departs (Specify) National Cemetery Other (Specify) Depertment of I Important: If ite any Injury or ot 4/2/07 Triangle, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Molesworth-Williams P.A., Funeral Home Pobb 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a. MYELODYSPLASTIC SYNDROME Due to (or as a consequence of): MONTHS Examiner RESPIRATORY INSUFFICIENCY WEEKS Completed by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician end for use as the burial-transit Due to (or es a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown NEUTROPENIA SEVERE ANEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? DEMENTA DEPRESSION 1 Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide

ieral Director: After this certific filled in by the funeral director,

MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AAR 2 6 2007

Largeeta Similate, M.D.

3411 OLANDWOOD COURTS # 105 OLNEY, MD SIMLOTE, M.D. SANGEETA 32. Registre Signature 31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

D50276 MARCH 24 2007

Registrar

Medical

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAR Stanton : 15AM **Physician** Charles Henry 2007 22 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hot 410 Frederick Frederick 800 Motter if Under 1 Year | if Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdav) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 212-24-7207 1/M 20F Days Hours 12, Md. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State ral", or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Frederick Frederick Md. Completed by Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 800 Motter Ave USA 21701 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 22 No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant; if item 27 is marked other than "natural", or iter any or other traumafic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1☐Yes 2☑No Specify: Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FREDERICA Elementary/Secondary (0-12) College (1-4or 5+) STRIPPER ANISHING 5 ta 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanton Elizabeth Brown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 445 Salem Ave Apt 2 Hagerslown Md. 21740 Shirlev Jackson (niece) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages Department of I Important: If its any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Frederick Md. 3-26-07 arrian Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility 6 AR gand J. Md 21701 St Frederich WEST 110 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MOS Due to (or as consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Vause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Completed by Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy for Month Day Year 5 Other (specify) signed by the aid be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an CONAC page 2 autopsy or Attending Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2D No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 | Inpatient 2 | ER/Outpatient 3 | DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral (28a. Date of Injury (Month, Day Year) 28h. Time of Medical Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 53129 107

State Registrar 31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nate Heitzig (10 Solare X 610 Heitzing MAR 26 32. Registrar's Signature 2007

Registrar

IRVING

CARLTON

State

31. Date filed (Month, Day, Year)

MAR 27

2007

egistrar's Signature

Leonardrows

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** <u>Virginia Eleanor Saunders</u> 29 2007 /Medical March 1:55 p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Solomons Nursing Center Sol<u>omons</u> Calvert If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreigr Country) 1 □ M 2 💢 F Months Days Hours Director 366-54-7306 99 07-11-1907 Michigan Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland St. Mary's Lexington Park 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 23320 Rolling Court 20653 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. ☐ Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White Completed by 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Gustav Johnston Emma Lundgren 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lyn Schramm/ Daughter 23320 Rolling Court, Lexington Park, Maryland 20653 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cr. 03-31-2007 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cong days /Medical Due to (or as a consequence of). Examiner Son Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 100 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 2 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury 27. Manner eath s after death. Il Director: After t Certification: 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 V atural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determine 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 29a, Certifier 1 🖖 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date/signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210SP RD ANWAR MUNSHI M.D 110

State

31. Date filed (Month, Day, Year)

MAR 3 0 2007

egistrar's Signature



Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Yeer **Physician** March 28, 2007 6:30 A^M Elizabeth Farmer Stevenson /Medical 4e. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Oeath Examiner St. Mary's Leonardtown St. Mary's Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months 1 ☐ M 2**X**) F West Virginia 12-18-1921 Director 236-22-3003 85 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, it a Medical Examples multipled at 1 Yes 2 No Director St. Mary's City Maryland St. Mary's 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20686 United States 47845 Buena Vista Lane Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? within 72 hours after 1 ☐ Yes 2 No 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White If Yes, Give Year or Dates: þ 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within if Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) Coltege (1-4or 5+) U.S. Government 12 Data Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roonie Blanche Frame Edward Jeremiah Farmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 Nick Stevenson/ Son P.O. Box 10, St. Mary's City, Maryland 20686 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 'Department of the Important: If ite 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 04-06-2007 Arlington, Virginia Arlington National 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licenses Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Physician /Medical MAZS 6a Aw Intestinal bleeding **Examiner** Sacuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine 575 physician and s the burial-transit Unhaly Isaer Due to (or as a consequence of) 46465 1470 r trusio Physician/Medical as the attending IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 14 pronths?
1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 90 1 Yes 2 No 3 Probably 4 Nown Anemic Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 1 ☐ Yes 25. Was case referred to medical examiner? filled in by the funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: or Attending Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cestifier 100061719 March 28 2007 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) Dhananjay Bhavsar, 24035 Three Notch Road, Hollywood, Maryland 20636 2. Registrar's Signature State 2007 Registrar

Elizabeth

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Jo Ellen Swope 24 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Avalon Manor Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 ☐ F 219-74-8520 Director 44 Nov.21,1962 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14014 Marsh Pike 21740 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □ Yes 2 No þ 3 ☐ Widowed 4 Divorced Specify. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Disabled traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ John Swope Elizabeth Catherine and A 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health am 27 i Robert L. Dove - Uncle Denim Lane Kearneysville, West Virginia other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 ment of I-tant; If its permit. Pages Department of Important: If it any injury or or 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 5 Other (Speelly) 4 □ Donation Smithsburg Crematory Mar.26,2007 Smithsburg, Maryland 21. Signature of Funeral Son OSborne Function, P.A. 425 S. Conococheague St. Williamsport, 23a. Part1. Enter ty disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Chrinic othernal /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) aw requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown s gned to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed autopsy 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 1 1 1 1 1 1 P 3 DO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

						24a. Was an autopsy performed? 1∐ Yes 2. LL No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No			
ed to medical				26. Place of Dea	ath (C	Check only one)				
10	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA	Other: 4 Nursing H	lome	5 ☐ Residence 6	Other (Specify)			
5 ☐ Pending investigation		28b. Time of Injury	1	njury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred					
6 ☐ Could not be determined	e 28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fact	ory, offi	ice	28f	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
1 ☐ CertifyIng Ph 2 ☐ Medical Exar	nysician: To the best of my known miner: On the basis of examination and manner stated.	owledge, death occurr ation and/or investigat	ed at th	ne time, date and place my opinion, death occu	e, and	d due to the cause(s) at the time, date and	and manner as stated. place, and due to the cause(s)			
itle of certifier			29c. Lic	ense number		29d. Date	e signed (Month, Day, Year)			
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ess of person who	completed cause of death (Iter		1 7	HALE	es.	TOWN,	MD 21740			
MAR'27	32. Registrar's Signature	B. Soul	U							

Vear

Black, White, etc.

Washington

Maryland

7:44

Birthplace (State or Foreign Country)

White

<u>Maryland</u>

Approximate Interval Between Onset and Death

Day

Year

10d. Inside City Limits

1 ☐ Yes 2 X No

2007

10H-0 State

within 2

Hospital or Attending

DHMH 17 Rev 1/2001

Registrar

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only

29b. Signature and title of certifier

31. Date filed (Month Pa) Year) 7

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certification:

			Please	e Type or	Prir	nt in Bl	ack	Inde	lible Inl	c. Ens	ure A	II Copies	Are I	_egi	ble.	
		For State		State	of Ma	aryland		•				1ental Hy	giene			
		Registrar 1. Decedent's Name (i	Eirot Middle	201)				Sertifi	icate of	Death	7	2. Date of De	Reg. No.	21		3. Time of Death
Physici		Low	Ann	So	:11							Month	Day	2/	Year	10:16 AM
/Medic Examin		4a. Facility Name (If no	ot institution, g	ive street and n	u <i>mber)</i>	1		4b	. City, Town,	or Location		I TOUR CONT	4c.	County	of Death	
		Washingto						15		Hager				W		ngton
Funeral Director		5. Social Security Num		Sex 1 □ M 2√1√F	7. Ag	e (In yrs. la 59	st birthi Yı	Mo	Under 1 Yea onths Day		er 24 Hrs. Min.	8. Date of Bir (Month, Di July 2	ay, Year)	7	Cou	place (State or Foreign Intry) SOUL i
D D		307-50-5138 Usual Residence of De	ecedent									July 2	1,124			
arylar show d at	ž	10a. State 1	0b. County			10c. City,	Town									10d. Inside City Limits 1XX es 2 ☐ No
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r deat ems 2	Funeral	11. Marital Status		12. Was De Armed F	cedent orces?	Ever in U.S	.]	13. Was	Decedent of	Hispanic C	Origin? (Sp	ecify Yes or No Rican, etc.)	0-		e - Amer	ican Indian, . etc.
S afte	by Fu	1 ☐ Never Married 3 ☐ Widowed 4		1 □ Yes If Yes, 0 Year or	ive	No			Yes 2 N			,		Specify		
ILE IS-UUSO filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	ted t	1:	5. Decedent's	Education			16a. D	ecedent'	s Usual Occ	upation			16b. Kir	nd of B	usiness/li	White ndustry
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VICITY CALLA IN CALLA	Ţ	Homer 19a. Informant's Nam			11, 1	01.	19b. N	Mailing A	ddress (Stre			ral Route Numb				ip Code)
and 2 and 2 ealth a n 27 is		Ken A. Sto		Husband					cotah	Aven		lagerst			<u>-</u>	
partilliore, Inda yialla ZIZIS-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at once.		20a. Method of Dispos 1 ☐ Burial 2	sition Cremation 3	☐Removal from	n State	20b. Pla	ace of E metery,	Dispositio cremato	n (Name of ory or other p	lace)		Date	20c. Lo	cation -	- City or T	Town, State
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Depa Depa Impo any ir		Y -	20	Ale				1				ne, P.A. ne St. V		ams	port	21795 , Maryland
H. F.		23a. Part I. Enter the shock, or he in	disease, or co	omplications that	caused each li	d the death.	Do no									Approximate Interval Between
Physician		Immediate Cause (Findisease or condition resulting in death)	nai	_a. M	ETA	-SIMI	10	EN	'Dome	2112	CA	NCER				Onset and Death
/Medical Examiner		resulting in death)			1.6	a conseque	ence of	$\rho = c$	PIRMI	m 7	I	1.1.1 =				
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ath cert	an/M	IF FEMALE: 23b. Was decedent p		23c. If yes, o		pf pregnan 2 □ Fetal		3⊟Ect	opic pregna	ıcv			1		ate of deli	
the att	sici	in the past 12 m 1 ☐ Yes 2 ☐ I 9 ☐ Unknown			gnant a	t time of de			her (specify)					IVI	onth	Day Year
that the ded by detac		Part II. Other signific	ant condition	s contributing to	death b	ut not resul	ting in t	the under	lying cause	given in Par	rt I.	23e. Did	tobacco u	ise con	tribute to	the cause of death?
law requires that some as been signed 2 should be a	ed by	C Los	MIGINTZ	m D	IFF	ICILE	C	5217	7.5			1 🗆	Yes 2[□No	3□ Pro	obably 4 □Unknown
law re as bee	Completed	INTR	LA ABD	OMINA	INF	Ection	N (NITH	KLOR	SIGL	A	24a. Wa	s an opsy	24b.	Were au	topsy findings available
The	Con											per 1□ Yes	formed?		death? 1 ☐ Yes	
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ttending leath. tor: Afte the fune	atio	1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigated 6 ☐ Could no	tion	mar, Da	ly real)				Yes 2	□No					
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the Ho in 24 h the Fu ipletely	Medical	(Check only 2	P. ☐ Medical E	kaminer: On the and ma	basis o		on and	or invest				rred at the time				
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		sician		1. Decedent's Name		n Flem	ing S	pooner			-		2. Date of Do Month March	Da	y Year 2007	3. Time o	
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	Fune Direct			5. Social Security Nur 222-03-09	mber 6. Se		7. Age (Ir	yrs. last birt		Under 1 Yes onths Day	ar If Und	er 24 Hrs.	8. Date of Bi (Month, D. June 2	rth ay, Year		rthplace (State country) Pennsylv	
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DC.	permit. Peg Department Important:	DOCE.		20a. Method of Disposition 1 © Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Sign ure of Funeral Service\Licensee 20b. Place of Disposition (Name of cemetery, crematory or other place) Principio Cemetery 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, Perryville, Maryland 21903-0766												•	and
0/10 10/	cate be executed Cate be executed Cate bourselve and cate but all the purial-transit	er	2	23a. Part1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death) Sequentially list condition and the sequentially list conditions. Enter Undert Cause. Enter Undert Cause (Disease or in that initiated events resulting in death) La	I failure. List only of Final of the control of the	Due to	or as a co	onsequence of	Who on:	ne mode of c	lying, such	as cardiac	or respiratory a	arrest,		Approxima Interval Be Onset and	tween
3/29	ath certification or use as	an/Me) Sicial English	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 🔀 9 ☐ Unknown	months?		birth 2 nant at time	pregnancy Fetal death e of death		opic pregna her (specify)		35230			23d. Date of d Month	elivery Day	Year
- E	quires that the de	<u>ء</u>	2	Part II. Other signific	cant conditions co	ntributing to d	leath but n	ot resulting in	the unde	rlying cause	given in Pa	rt I.		tobacco Yes 2	use contribute 2 □ No 3 □ F	2	death? Unknown
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V# 2	Hospita 24 hours Funeral	ilcal Cer	DO INCIDENTAL PROPERTY OF THE	29a. Certifier (Check only one)	Certifying Phy	sician: To the	e best of m	ny knowledge amination an	, death oc	curred at the	time, date y opinion, c	and place	, and due to the	e cause(:	s) and manner and place, and du	as stated.	(s)
•	To the To the Comple	M		29b. Signature and to	Tomes	Lear	ido	KID	Type, Prir	2	428	er 200	//	29d. D	ate signed (Mor	nth, Day, Year)	
	8 Bas	State		31. Date filed (Month	A. Int	32. F	Registrar's	3/ Signature	4. 4	Sperte	iols	org	HOR W	14	14, 21	078	

07-02185

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Ryan Simpson 1 - For State Certificate of Death Rea No Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ March 21, 2007 1657 hrs Medical Examiner Simpson Marquess 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Charles Civista Medical Center La Plata 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Maryland Hours Months Days Director 214-33-9161 1 X M 2 F 15 July 1, 1991 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 X No 23a or 28a-f show notified at once. MD Charles La Plata with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe U.S.A. ā 170 Wood Duck Circle 20646 14. Race - American Indian, Black Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12. Was Decedent Ever in U.S. items Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married 2 Yes ō Specify: white. 1 Yes 2X No specify: 3 Widowed Divorced f Yes, Give Year à 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 lent of Health and Mental Hygiene student 10 none 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Deborah Tynn Simpson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Malcolm George Ma 19a. Informant's Name/Relationship (Type, Print Marquess nt of Health and M it: If item 27 is in other traumatic 70 Wood Duck Circle, LaPlata, MD 20646 Deborah L. Simpson, Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Burial 2 Cremation 3 Removal from State crematory or other place) ment tant: 03/26/2007 La Plata, MD Donation 5 Other Specify Sacred Heart Cemetery 22. Name and Address of Facility 21 Signature of Funeral Service Rausch Funeral Home, P.A. omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear MD Approximate Interval er the disease, or **Physician** Between Onset and List only one cause /Medical Death a. Asphyxia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Hanging Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical AMENDED UNPENDED death certificate be 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy ing physas the b 23b. Was decedent pregnant in the Month Day 3 Ectopic pregnancy Year I ive birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ≥ Yes 2 ✔ No 3 Probably 4 Unknown ۵. Completed Records, 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy has 2 s performed? death? 1 🗸 Yes ✓ Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Attending Physician: Be of Vital Other₄ examiner? Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 Nursing Home 5 Residence 6 Other: DOA this 1 🗸 Yes 28c. Injury at Work 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28d. Describe how injury occurred After 27. Manner of Death Certification: Subject hanged self FOUND: Natural Division Yes 2 V No Pending death. Mar 21, 2007 1620 hrs Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be Hospital or or Town, State) 170 Wood Duck Circle, La Plata, MD determined (Specify) Single Family Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. March 22, 2007 /erasse 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD Assistant Medical Examiner 31. Date filed (Moral AR 2 32. Registrar's Signature 3 2007

Registrar

permitt. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Copartment of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show an any Injury or other trainmaits event the Medical Examiner must be notified at 19.		Dalilliole, Iwai yialid 21213-0030	
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Physicia /Medic Examin

Funeral

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Stack, Howard Francis 3/21/07 9:44 pm Division or Vital Records, P.O. Box 68760, 10

	For State	State of M	laryland / D	epartm Certific	ent of F	lealth a Death	and M		giene 2	007	7 1107	16
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n	Howard Francis	Stack						Month	21, 20	Year	9:44 p	M
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100	Suburban Hospital 5. Social Security Number 6. Sex		ge (In yrs. last birtf	nday) If Ur	Bethes nder 1 Year	If Under		8. Date of Bir	th	ntgor 9. Bin	thplace (State or Fore	ign
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to be completed by Funeral Director	15. Decedent's Educ	cation	16a. I	Decedent's I	Jsual Occup	ation			16b. Kind of	Business	/Industry	
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e C	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle	, Maiden Surr	ame)		
0	James A. Stack					M	arth	a A. C	linton			
-	19a. Informant's Name/Relationship (Typ	oe. Print)	19b.	Mailing Add	ress (Street	and Numbe	er or Rura	al Route Numb	er, City or Tov	vn, State, a	Zip Code)	_
	Mary Eileen Steven	s/Daught	er 11	602 Ma	nolevi	ew Dr	ive.	Wheat	on, MD	20902	2	
	20a. Method of Disposition		20b. Place of	Disposition (Name of	;		Date			Town, State	
	1 Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cometan	y, crematory	or other plac		v	rch 26		•	·	
	4 □ Donation 5 □ Other (Specify)		54.55	į electriciai.			2				ng, Maryla	nd
	21. Signature of Funeral Service License	ie) ale		Franc 500 U	Jniver	sity	ins Blvd	Funeral	l Home ilver S	Inc. princ	g, MD 2090	1
	23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that cause	ed the death. Do n	ot enter the	mode of dyir	g, such as	cardiac o	or respiratory a	arrest,		Approximate Interval Between	
	Immediate Cause (Final	e cause on each	iirie.								Onset and Death	
	disease or condition resulting in death)	Cerebr	al Infaros a consequence o	gtion								
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M	IF FEMALE:	On Huma autaam										
O	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		ic pregnanc	/				Date of de Month	livery Day Year	
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be completed by Physician/Me	Part II. Other significant conditions cor		but not resulting in	the underlyi	ng cause giv	en in Part I	•				o the cause of death?	
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<u> </u>								24a. Was		b. Were a	utopsy findings availa	ble
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	examiner?	lospital: 1 [¥inpat	tient 2 ER/Out	nationt 2F	DOA Oth	or:				241		_
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Š	3 Suicide 6 Could not be	28e Place of it	njury - At home, far			103 2		29f Location	(Street and No	mher or B	lural Route Number,	
	4 ☐ Homicide determined	building, e	etc. (Specify)	m, street, ra	ctory, office			City or To	wn, State)	mber or ri	urar rioute rearriber,	
Medical Certification:		N'		4								
Ca	29a. Certifier 1 Certifying Phys (Check only 2 Medical Exami	ner: On the basis	of examination and									
ed	one)	and manner s										
>	29b. Signature and title of certifier				29c. Licens				/	ned (Mon	th, Day, Year)	
	P BESC				7000	1302			3/22/	0+		
	30. Name and address of person who co	mpleted cause of	death (Item 23a) (Type, Print)					11			
	Atul Rohatgi, M.D	9901	Medical	Cente	er Dri	ve, R	ockv	ille, N	1D ⁽ 2085	0		
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he Ma 28a-f	Director	MD Wicomi	.co Sal	lisbur	<u></u>			100	Citizen of	What Cour	•	
with t a or 2		10e. Street and Number			10f. Zip Code 2180	1			USA	Wilat Cour	iuy:	
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after or iter		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		If Yes, specify Cuba 1 ☐ Yes 2X No	n, Mexican, P	uerto Rican, e	tc.)		ick, White, fy: Whi		
ours ural",	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. Do NOT use retired)											
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be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, La	st)			18. Mother's	Name (First, i	Middle, Maid	den Surnai	me)		
Menta	To E	Clinton Webster				Mable	Taylor					
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	Removal from State	cemetery, cre	matory or other plac emetery	1	-26-200				, Maryland	
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permi Depa Impo any Is		K Junes &	Telly	7	05 E. Mai	n Stree	et. Sal	isbur)4	
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The law te has age 2 s	omp						_	autopsy performed Yes 200		death?	mpletion of cause of 2□ No	
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ing P. After 1 funera	ion:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl		28d. De:	scribe how i	nju r y occu	rred		
Attende death ctor:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time or Injury M 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Des											
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To the within comp	Me	29b. Signature and title of certifier	w Draa		29c. Licenso		76	29d.	Date sign	ed (Month,	Day, Year)	
7		30. Name and address of person wh	no completed cause of death (Iter	n 23a) (Type	Print) JAK	TES C	W. 14	SAAC	5,~	3	ALKBU124	
Sta	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAMES W. ISAACS, SALKBUIZY (DASTRE HOSTICE ATT THE LAKE, TREESIHEAT) (+057) TAZ (ATT) 2180 (-) State istrar MAR 2 2 2007 Manu & Apple											
Registr		MAR 22	2 2007 Kanne	K.	bosile							
UMU 17 Day 1/0					Maria 1							

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8:45 p M 16 2007 MARCH **JOHN** TRUESDALE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges Hospital Prince Georges Cheverly If Under 1 Year It Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country)
 S.C. 8. Date of Birth (Month, Day, Mar 3, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral 1929 Months 1 3 M 2 F 77 Director 241-32-8320 Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-1 ehow empirioury or other traumatic event. The Modical Examination in collines at an increase. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 ☐ No Director Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1430 T. St. N.W. 20009 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No 11. Marital Status 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Yes, Give **Black** 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) MD Highway Patrol 9th Maintenance 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Carrol Truesdale Gullar Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1322 New Garden Rd. 27410 Samantha T. Arrington/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 3-24-2007 4 □ Donation 5 □ Other (Specify) Alexandria, Va. 22 Name and Address of Facility
Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, D.C. 20011 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIAC Immediate Cause (Final ARRHYTHMIL FATAL **Physician** disease or condition resulting in death) /Medical Examiner ung Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot) Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome ot pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day Year Month in the past 12 months? 5 Other (specify) 4 Pregnant at time of death P.O. 23e. Did tobacco use contribute to the cause of death? After this certificate has been signed funeral director, page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy tindings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed: 1 Yes 2.X No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide 124 hours a filled 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and tite of certifie 29c. License number D064478 30. Name and abeless of person who completed cause of death (Item 23a) (Type, Print) CHEVERLY, MD 20185 MEHARI 3001 HOSFITAL FISE HAT SION MD 31. Date filed (Month, Day, Year)

MAR 2 2 2007 32. Registrar's Signature Stäte Registrar

DHMH 17 Rev 1/2001

ORIGINAL

07-02085 Derrick Taylor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

errick Taylor		State of Maryland / De	epartment o Certificate o			2001	7 1107
Physicia Jedical Examir	ın/	Registrar 1. Decedent's Name (First, Middle,Last) Derrick Demar Taylo	r	-	2. Date of Dea Month March 17	ath Day Year	3. Time of Death 0132 hrs
		4a. Facility Name (if not institution, give street and number) 3834 Regency Parkway	_	4b. City, Town, or Location Suitland	of Death	4c. County of Death Prince George	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In 1.1.4 M 2 F 1.1.4 M	yrs. last birthday) 9 Yrs	Months Days Hour	e Min	th(MM/DD/YYYY) 9. Bir Foreig y 13,1988 Co	in
ow any	-	Usual Residence of Decedent 10a. State 10b. County 10c. Maryland Prince Georges	City, Town or Local Temple				10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e Street and Number	тешрте	10f. Zip Code	1	10g. Citizen of What Cour	
the M. a or 2	Dire	7107 West Chester Drive		20748		United St	ates
r death wi or items	Fune	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X 3 Widowed 4 Divorced If Yes, Give Year	If Y	as Decedent of Hispanic Or Yes, specify Cuban, Mexical Yes 2 X No specify	n, Puerto Rican, etc.)	White, etc.	can Indian, Black,
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	eted by	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)	ed) 16a. Deceder during m	nt's Usual Occupation (Give	kind of work done	16b. Kind of Business/	
3036 within 72 iene.	Completed	12th grade	Di	spatcher	The state of the s		ble Company
21215-0036 outd be filed within 7 1 Mental Hygiene, 5 marked other than ic event, the Medica	a	17. Father's Name (First, Middle, Last) Garrett Clayton Taylor 19a. Informant's Name/Relationship (Type, Print)	10h Mailin		The second secon	ristina Joh	nnson Zin Code)
e, MD 2 L and 2 shoul Health and N Fitem 27 is rr	٩	Veronica C. Taylor (Mother)		West Chester			
- s - = o		1 X Burial 2 Cremation 3 Removal from State	crematory or of	sition (Name of cemetery, ther place)	March 24,	20c. Location - City or Brentwood,	·
Baltimore, permit Pages I a Department of He Important: If the Important or other tringing or other tr	1	4 Donation 5 Other Specify: 1. Sign e of Funery Struce/Licque		Name and Address of Facili R. N. Horton OO Kennedy St			
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the of failure. List only one cause on each line. Immediate Cause (Final disease a Gunshot Wound of	death. Do not enter	the mode of dying, such as	cardiac or respiratory an	rest, shock, or heart	Approximate Interval Between Onset and Death
		or condition resulting in death) Due to (or as a consequence b.	nce of):				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated					
executed an and al - transit		events resulting in death) Last Due to (or as a consequent d.	nce or):			<u> </u>	
sici pe	edical	UNPENDED AMENDED				1	
OX 6876 eath certifical eath cutifical attending ph for use as the	ΣΙ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	2 Fe	etal death 3 Ectop	oic pregnancy	23d. Date of deliver	y Day Year
ords, P.O. B w requires that the d s been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but	t not resulting in the	underlying cause given in F		tobacco use contribute to	
Division of Vital Records, ral or Attending Physician: The law requirers after death al Director: After this certificate has been siled in by the funeral director, page 2 should the	Completed				24a. Was auto perfo 1 🗸 Yes	psy prior to ormed? death?	utopsy findings available completion of cause of es 2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient	2 ER/Outpatien	Other	Nursing Home 5	Residence 6 🗸 Othe	r Scene
ion of Vi tending Physi eath tor: After this the funeral dir	ion: To	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending Mar 17, 2007 1 Natural 5 Pending Mar 17, 2007	28b. Time of 0120 hrs	t o bon	rk? 28d. Describe	how injury occurred	
Division pital or Attent ours after death neral Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Multi-F		eet, factory, office building,	or Town,	(Street and Number or Restate) cy Parkway, Suitland,	
To the Hospit within 24 hour To the Funeric completely fill	Medical C	29a Certifier (Check only one) Certifying Physician: To the best of my knowne) 2 Medical Examiner: On the basis of examina	owledge, death occu ation and/or investiga	urred at the time, date and pation, in my opinion, death o	place, and due to the cau	use(s) and manner as star e and place, and due to the	ne cause(s)
To Too	Me	29b. Signature and title of certifier	5	29c, License numbe O.C.M.E.	er	29d. Date signed (Mo	nth, Day, Year)
0 (4)		30. Name and address of person who completed cause of death		Penn Street, Baltimo	re MD 21201	1	
St Regist	tate	Melissa Brassell, MD Assistant Medical Ex 31. Date filed (Month, Day Year) AR 2 3 2007		Term Gueet, Daillino			· · · · · · · · · · · · · · · · · · ·

DHMH 17 Rev 1/2001 OCME 2006 3altimore, Maryland 21215-0036

burial-tran and Division or Vital Records, P.O. Box 68760.

State of Maryland / Department of Health and Mental Hygiene

1- State Amend #1 per PHYS/FH 03-29-2007 CNM Reg. No.

Reg. No. Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death George Heisler Roberts Taylor Month Physician GEORGE HEISLER TAYLOR 23 2007 7:15 A M MARCH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months I Davs Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 519-18-8026 Director NOV 8 1911 IDAHO Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD MONTGOMERY Director POOLESVILLE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 15711 HUGHES ROAD 20837 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Noves 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Oban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. ģ Specify: WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Me AFLCIO College (1-4or 5+) Elementary/Secondary (0-12) DIRECTOR OF OSHA 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM O. TAYLOR CAROLINE ROBERTS ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLINE V. TAYLOR/DAUGHTER 15711 HUGHES RD., POOLESVILLE, MD 20837 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State STAUFFER CREMAT. 3/24/07 FREDERICK, MD 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service 22. Name and Address of Facility HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, MD 20838 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Dreumon, a disease or condition resulting in death) /Medical Di to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) signed by the aid be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 227 No death? 1 ☐ Yes 2□No 1∐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours aft To the Funeral D 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier D 60557 Prostuce M.O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVILLE, Md. 9901 Medical Car. DR. LEO Shue MD 32. Registras Signature 31. Date filed (Month, Day, Year) State MAR 2 6 2007 ▶ Registrar

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		4	Please State Registrar			Departmen	nt of Health and te of Death		ne nn 7	11081
1	Physici	an	1. Decedent's Name (First, Middle, Las David L . Tyson					2. Date of Death Month March 22	2°, 2007	3. Time of Death 5:30PM M
	/Medic Examir		4a. Facility Name (If not institution, give Fort Washingt	street and number) on Healt	Cente h& Re	r 4b. City	Town, or Location of Deat ort Washing		4c. County of Deat	h
40	Funeral Director		5. Social Security Number 235-56-3416 6. So	7. Age 3x 2 F 6	(In yrs. last t	Yrs. If Undo	or 1 Year If Under 24 Hrs Days Hours Min.		9. Bird 938 Wes	hplace (State or Foreign ountry) Va .
***	70	tor	Usual Residence of Decedent 10a. State MD 10b. County P • G •		10c. City, To Fort	wn or Location Washir	gton			10d. Inside City Limits 1 □ Yes 2 □ No
	with the	I Director	10e. Street and Number 906 East Tanta	llon Dr.		10f. Z	ip Code 20744	10g.	Citizen of What Co	ountry?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, it a Medical Examinar must be a coffied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1X Yes 2 N If Yes, Give Year or Dates:		13. Was Dec If Yes, sp	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer 21X No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit Specify Bla	e, etc.
5-0	"natur	Completed by	15. Decedent's Ec (Specify only highest gra	de completed)	16	Sa. Decedent's Us (Give kind of w _ life. DO. NOT	ual Occupation ork done during most of wo use retired) Tation Tec	orking I 16b	. Kind of Business	
212	d withir giene. or then	omo	Elementary/Secondary (0-12)	Coilege (1-4or 5	+) A	dminist	ration Tec	hnician		
Maryland 21215-0036	2 should be filed to and Mental Hygiers and Mental Hygiers and the standard other raumatic event, It	To Be C	17. Father's Name (First, Middle, Last) Ether J. Tyson				Magg	me (First, Middle, Maid ie Myers		
	and 2 shouealth and N m 27 is mainer traumsi		19a. Informant's Name/Relationship (Doris Tyson	Type, Print) Wife	1	9b. Mailing Addre 906 Eas	ss (Street and Number or Fi t Tantallo	n Dr. For	t Washi	Ington MD
Baltimore,	Pages 1 an ent of Heal nt: If Item 2 ry or other		20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)		Che.	of Disposition (N teny, crematory of LCenham	other place) Mare	ch30,07 C	Location - City or heltenh	Town, State am MD
Balti	pernit. Pages 1 Department of H Important: If Ite any injury or ot		21. Signature of Funeral Service Licer	Parbin	ra D	Robi	and Address of Facility nson funer	Wash D	313 ²⁰⁰⁰	1 St.N.W.
	Physician /Medical Examiner	_	23a. Pary Enter the disease, or comshipt, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	plications that caused one cause on each lir a	ne. h b S a consequence NON	is of	ode of dying, such as cardial of the control of the			Approximate Interval Between cheet and Death L We WE
68760,	icate be executed physicien and s the burial-transit	edicai Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as						
P.O. Box (Attending Physician: The law requires that the death certificate reath. sctor: After this certificate has been signed by the attending physby the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	ath 3 ☐Ectopic			23d. Date of de Month	elivery Day Year
ds, P.	signed by	þ	Part II. Other significant conditions	contributing to death b	ut not resultin	g in the underlyin	g cause given in Part I.			to the cause of death? Probably 4 Nunknown
of Vital Records,	The law require ate has been si page 2 should b	Completed						24a. Was an autopsy performe	prior to	nutopsy findings available completion of cause of
/ita	ysician: The is certificate h director, page	Be	25. Was case referred to medical examiner?	Hospital:			Other	eath (Check only one)		
of	Phys r this ral dir	To	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ent 2 ER	b. Time of	28c. Injury at Work?	Home 5 Residence 28d. Describe how		ecity)
Division	I or Attending Ph after death. Director: After th	Certification:	1 X Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not t 4 Homicide determined	e 28e. Place of Inj		Injury M , farm, street, fact	1 Yes 2 No	28f. Location (Stree City or Town, S	et and Number or F State)	Rural Route Number,
_	Hospita 4 hours Funeral ely fillec	Medical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best miner: On the basis o and manner st	f examination	dge, death occurr and/or investigat	ed at the time, date and pla on, in my opinion, death oc	ce, and due to the cau- curred at the time, date	se(s) and manner a and place, and du	as stated. ue to the cause(s)
)	within 2.	Me	29b. Signature and title of certifier	3/1	2		29c. License number 245	35	Date signed (Mor	Day, Year)
1	(2)		30. Name and address of person who Laxmi N. Be		death (Item 23	3a) (Type, Print) 7700 O1		ce C-101		
1	St	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Sign	N)				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 3 **Physician** 10:30 A M homas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner town 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Funeral 1 □ M 2 KF Min Months Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 le marked other then "naturel", or Itame 23e or 28a-f show eny Injury or other traumatic event, Ira Medical Examiner most by multified at once. 10a State 10b. County 10c. City Town or Location 10d. Inside City Limits 1 Yes 2 □ No Completed by Funeral Director Ken 10g. Citizen of What Country? 10f. Zip Code Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 1 □ Never Married 2 □ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be 19b. Mailing Address (Street and Number State, Zip Code) sister. Date 20b. Place of Disposition (N 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should be reported by the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final > 10 years Physician ARTERY URUNARY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ certificate has been signe rector, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown STENOSIS Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes 2 No : After this certifica e funeral director, j To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 10 Other: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3∏ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending within 24 hours effer death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🜠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

A. noble

Speer 32. Registrar signature MAR 1 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ChesTERTOWN

Suite 5

29d. Date signed (Month, Day, Year)

MD

2007

21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3-26-2007 **Physician** EDNA LOUISE VAN DYKE 3:32A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 3953 OLD WASH.RD. CHARLES WALDORF 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 1-15-1938 **Funeral** 9. Birthplace (State or Foreign Hours 1 M 2 X Yrs GĔÖRGIA 413-52-6504 69 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐Yes X☐No CHARLES WALDORF MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3953 OLD WASHINGTON RD. 20602 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ ੴ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be VIOLET O'NEAL THOMAS JONES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau ROBERT F.VAN DYKE, SR.-SPOUSE 3953 OLD WASH.RD. WALDORF, MD. 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ACremation 3 Removal from State PROPOLITAN CREMATORY 3-30-07 ALEX., VA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses M004Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached for ☐ Yes 20 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient Other: 19€Yes 2□ No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. After Injury at Work? 28d. Describe how injury occurred Injury (DXNatural after death.

Director: Aid in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14900VI 00550383 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) plata Year) 32 Registrar's Signature State 31. Date filed (Month

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** March 25, 2007 8:15 a^M May Lola Vankirk /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Yrs Director 89 214-12-8972 01/30/1918 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or forther traumatic event, the Medical Examiner must be notified, at 10a State 10c, City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country Funeral 27080 Beachview Lane 20659 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify Completed by Specify: 3 X Widowed 4 Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 James Buckmaster Effie Parks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joe L. Vankirk/Son 27090 Beachview Lane, Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem 03/29/2007 Cheltenham, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** days /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a Physician/Medical Examiner siclan and burial-transit Due to (or as a consequence of) sician the attending pl for use as t nse IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal deat 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. after death Director: the 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a

the Hospital or Attending Physician: The law requires that the death certificate be executed Records, P.O. Box 68760, Division or Vital

Baltimore, Maryland 21215-0036

To the Hosp within 24 hor To the Fune completely f

State Registrar 29a. Certifier

Medical

29b. Signature and title of certifie

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

> 24035 Three Notch Road, Hollywood, Maryland M.D

James P. Jarboe, 31. Date filed (Month, Day, Year) 32. Begistrar's Signature

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Jose Marcos Portillo Villalta	State of Maryland / Department of Health and Mental Hygiene		2007	1100
1- For State	Certificate of Death	Reg No	2007	1100

		1- For State Registrar	Cert Jose Marcos Vill	ificate of				Reg. No.	001 1100
Physici		Decedent's Name (First, Middle,Last)	eath	3. Time of Death					
Medical Exam	iner	Jose Marco	s Portill	. o - V	illalt	a	Month March 1	9, 200 7 Ye	^{ar} 2345 hrs
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Funerai		Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Yea	r If Under	24Hrs. 8. Date of B	Birth(MM/DD/YYY	Y) 9. Birthplace (State or
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th the Maryland 23a or 28a-f sho notified at once.	Director	10e Street and Number 5811 Eastpine 1	Orive		10f. Zip Code 207	37		10g. Citizen of W	hat Country?
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2 21 should ond Me is ma	L 2	19a. Informant's Name/Relationship (Typ		•			er or Rural Route No		
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	ate							<u> </u>	
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Maryland	and lame		19a. Informant's Name/Relationshi	p (Type, Print)		•		r or Rural Route Numbe			
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier Certifying	Physicien: To the bes	t of my knowledge, dea of examination and/or i	th occurred at the tir	ne, date and	d place, and due to the	cause(s) and mai	nner as sta	ted. the cause(s)
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			30 Name and address of person y	ho completed caude la	death (Item 23a) (Tuno	Print) /	12.	. C	- 700	·	
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	Regist	rar	APR 0 6 2	007 July 20.	1 15 ph	MEL)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#20b-20c.perFH, G866, 4/6/07 WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 0.3 Day 16 Physician WILBURN SR WRIGHT, MARCUS 2007 11:000 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Prince Georges County Hospital Cheverly If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 08-14-1937 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1√2 M 2□ F 69 579~50~1190 Director Georgia Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b Counts or than "natural", or Iteme 23s or 28s-f show the Medical Examiner must be natified at Capitol Heights MD Prince Georges 1 XYes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 **USA** 6 Maryland Park Drive e filed within 72 hours after death tall Hyglene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 → Yes 2 □ No If Yes, Give Year or Dates: 1954 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ↑ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Government Teacher 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Jury or other traumatic event 2008. Be Effie Towles Hubert Wright, SR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8504 Sky View Drive #202 Alexandria Va 22309 Lureta Wright Daughter Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham MD Veterans Cametery 4/9/2007 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) Wosh.D.C 22. Name and Address of Facility
Bianchi 814 Upshur St NW Wash, DC 20011 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final HEMORRAGE NTRA CRANIAL - 2007 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RESTIPATORY days. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner physician and s the burial-transit HEADT OFGESTIVE that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š RENAL INCUFFICIENCY 1 Yes 2 No 3 Probably 4 JUnknown Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No After this certification, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဥ 1 Tes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu М 2 Accident 6 Could not be 3 ☐ Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number D - 34 \$25 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

The law requires that the death certificate be executed

Records, P.O. Box 68760

Division of Vital or Attending Physician:

death.

NAPCO

NRIGHT

Baltimore, Maryland 21215-0036

with the Maryland

31. Date filed (Month, Day, Year)
MAR 2 2 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Jimmie Hayes Weston March 18 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Southern Maryland Hospital Clinton Prince George's Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days 1 □ M 2 XF 425-62-2023 Mississippi July 27, 1914 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Maryland Prince George's Clinton 10g. Citizen of What Country? 10f. Zin Code 10e Street and Number 9106 Pineview Lane 20735 <u>United States</u> 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married African 1 ☐ Yes 2 ☑ No Specify 3 ☑ Widowed 4 □ Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James B. Haves Theresa Black 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Saunders/Daughter 11011 Hillgate Lane, Glenndale, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Delta Memorial Garden 3/24/2007 Greenville, MS 21. Signa are of Funeral Service License 22. Name and Address of Facility Stewart Funeral Home Dewar Wash., DC 20019 4001 Benning Rd., NE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cause (Final disease or condition resulting in death) squartially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown

Physician /Medical Examiner

permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is i
any injury or other trausonce.

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

Director

Funeral

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Completed

Be

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Examiner

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

1 and 2 should be filed within 72 hours after death with Health and Mental Hygiene.
em 27 Is marked other than "natural", or Items 23a or wher traumatic event, the Medical Examiner must be In the traumatic event.

-burial-1 attending physician for use as the buria been signed by the s should be detached has le 2 page

law requires that the death certificate be executed certificate After this or Attending within 24 hours after death

To the Funeral Director: ,
completely filled in by the f

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome pf pregn 1	al death 3 □Ectopic			23d. Date of delivery Month Day Y	'ear
	ontributing to death but not res			23e. Did tobacce	o use contribute to the cause of do 2 Mo 3 Probably 4 □U	
Bilateral Preumon		7		24a. Was an autopsy performed		available ause of
25. Was case referred to medical			26. Place of D	eath (Check only one)		
1 Yes 2 10 0	Hospital: 1 Impatient 2	ER/Outpatient 3 ☐ I	DOA Other: 4 Nursing	Home 5 Residence	6 ☐Other (Specify)	
om 14 A 15 H	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
27. Manner of Death 12 Natural 5 Pending Investigation 2 Accident 3 Suicide 4 Homicide Homicide Homicide Homicide Pending Investigation Homicide Homicide	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, factory)	ory, office	28f. Location (Street City or Town, St	and Number or Rural Route Num ate)	ber,
29a. Certifier 12 Certifying Ph	ysician: To the best of my kniner: On the basis of examin and manner stated.				e(s) and manner as stated. and place, and due to the cause(s)
20h Signatura and titlered cartifier		2	9c License number	29d I	Date signed (Month Day Year)	

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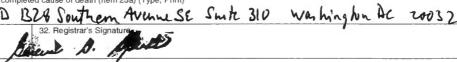
March 19 2007



Division or Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year) MAR 23 2007



ress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Amend #28b, perME, g866, 4/18/07 TT Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** March David Lee WELLER SR. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown
If Under 1 Year | If Under 24 Hrs. Washington County Hospital Washington Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral 1 ☑ M 2 ☐ F Months Days Hours Yrs. Director 214-48-4933 58 Oct. 24 1948 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City. Town or Location 10b County 10d. Inside City Limits 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Washington Sharpsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 17006 Powell Road 21782 items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black. White, etc. and 2 should be filed within 72 hours after on the and Mental Hygiene. n 27 is marked other than "natural", or ite 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Resley Weller Vesta Keefer ဂ or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: if Item 27 is any injury or other trau Vickie L. Weller - Wife 17006 Powell Road, Sharpsburg, Md. 21782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Green Lawn Mem. Park 3/29/07 4 ☐ Donation 5 ☐ Other (Specify) Williamsport, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home Kalut 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examiner and Due to (or as a consequence of): Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown sulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Dead 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient Certification: To 4 ☐ Nursing Home 5 Residence 6 QOther 27. Manner of Death Date of Injury 28c. Injury at Work? 28d. Describe how injury To the Hospital or Attending M23 Pay Injury 1 ☐ Natural 5 Pending death. investigation 5:30 am 1 Tes 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide injury - At home, farm, street, factory, office etc. (Specify) 4 Homicide BW el 006 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the calcals) and 2 Diedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla 29a. Certifier Medical (Check only one) cause(s) 29b. Signature a

State Registrar

			For State Registrar	State of Maryla		artment of H		,	giene Reg. No. 2	007	11090
			1. Decedent's Name (First, Middle, La	st)				2. Date of De	ath	<u> </u>	3. Time of Death
	Physici /Medi		ABIJAH JAMES	WILDER				Month March	22,	Year 2007	1:49 P M
X	Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	or Location of Deat	h	4c. Co	unty of Death	
			FREDERICK MEMOR				ERICK			REDERIC	
ь	Funeral		5. Social Security Number 6. S	Sex 7. Age (In) I∐AM 2□F 70	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	y, Year)	Coui	
	Director		Usual Residence of Decedent		110.			March	5, 193	// Mar	yland
	yland yland at		10a. State 10b. County	10c.	City, Town or Lo	cation				1	10d. Inside City Limits
	a-f sh	ctor	Maryland Frede	rick	Frederi	ck					1 □ Yes 2X No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?
	s 23a	ral	7285 Coach Ligh			21703			U.S.		
	items	nue	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14.	Race - Americ Black, White,	
36	rs aft	by F	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 2 No If Yes, Give Year or Dates:		1 □ Yes 2 🛣 No	Specify:		Sp	ecify: Whi	te
9	2 hou	led	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	pation		16b. Kind	of Business/In	dustry
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Completed by	(Specify only highest gra	ade completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wo d)	rking			•
21	ygien /gien er th	ē	9		Dr	ywall & I	Painting		Con	struct	ion
pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				me (First, Middle		rname)	
yla	12 should be filed within " h and Mental Hygiene. F is marked other than " traumatic event, <u>the Mec</u>	၉	Jesse Wilder					Sarah			
Maryland	12 sh h and 7 is rr traurr		19a. Informant's Name/Relationship (Ruth H. Wilder	,,		ng Address (Street					
	1 and 2 Health tem 27		20a. Method of Disposition		b. Place of Dispo	Coach Lig	gnt Court	Date Date		Maryla ion - City or To	
Baltimore,	T T		1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	matory or other pla ily Cemet	· ' :	27/07		•	
Ħ	permit. Pag Department Important: I any Injury o		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice)			2. Name and Addre		27707	Galtn	ersbur	g, Marylan
Ba	permit. Departr Imports any inju		Deather	um. Hobb		Moleswor 26401 R	rth-Willi idge Road			eral H arylan	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	leath. Do not en	er the mode of dyi	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
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		ē	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons		- 171.0-	217111	nde		_	
	ate be executed thysician and the burial-trar sit	Examiner	triat iriitiated events	C							
O,	ate be executed hysician and the burial-traisit		resulting in death) Last	Due to (or as a con-	sequence of):						
8760,	ate by hysici	dical	•	d							
9	entific ling p e as t	Mec	IF FEMALE:								
Box	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pre 1□Live birth 2□F	Fetal death 3[Ectopic pregnanc	y		23d	. Date of delive Month	ery Day Year
P.O.	the g	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5L	Other (specify) _					,
	that the ed by detact		Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco use	contribute to t	he cause of death?
rds	quires n sign lld be	d b						14	Yes 2□N	lo 3□Prol	ably 4 ∐Unknown
000	law rec as beer 2 shou	Completed by						24a. Was	an 2	4b. Were auto	ppsy findings available
Re	Ф <u>г</u> е	E C						auto perfo	psy prmed?	prior to co death?	impletion of cause of
ita	ician: Th certificate ector, pag	Be C	25. Was case referred to medical				26. Place of De	1 Yes ath (Check only o	2 MNo	1 ☐ Yes	2 □ No
>	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ☐ ER/Outpatie	nt 3 DOA Oth		Home 5 ☐ Resi		Other (Specia	fv)
0	ng Pt fter tt neral	ii.	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea.	28b. Time o	f 28c. Inju Wo		28d. Describe			
Sio	Attending r death. ector: After by the fune	atic	2 ☐ Accident investigation	n		M 1□	Yes 2 □ No				
Division or Vital Records,	l or Att after de Direct	Certification:	3 Suicide 6 Could not b 4 Homicide determined		At home, farm, streecify)	eet, factory, office		28f. Location (City or To		umber or Run	al Route Number,
	ospital hours al uneral C		20a Cartifiar 1 - Cartifician Di	verialism. To the best of mu	Iraquiladas, dest	h a a a	les determination				
	e Host 24 ho e Fund etely f	Medical	29a. Certifier 1 ✓ Certifying Pl (Check only one) 2 Medical Example (Check only one)	nysician: To the best of my miner: On the basis of exam and manner stated.	nination and/or ir	vestigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time	date and pla	d manner as s ace, and due t	tated. o the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Mec	29b. Signature and title of certifier			29c. Licens		<u> </u>	29d. Date s	igned (Month,	Day, Year)
	⊢ ≶ ⊢ Ö		> S/W12	MD		D 00	47951		3/2	5-2	007
			30. Name and address of person who	completed cause of death ((Item 23a) (Type.	Doo Print)	C				
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Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registra s Signature

MAR 2 6 2007 >

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time 2:00 2007 Year March 27, A M Calvin Jackson Worrell 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Charlotte Hall St. Mary's 29880 Three Notch Road If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 M M 2 □ F Months Virginia 69 May 225-44-2561 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. inside City Limits 10b. County 1 ☐ Yes ZXXNo Maryland St. Marv's Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20622 29880 Three Notch Road 12. Was Decedent Ever in U.S. Armed Forces? 1∰Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2XX Married 1 ☐ Yes XX No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lumber Company Sawver 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lorraine Louise Phibbs Emmett William Worrell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ella Mae Worrell / Wife P.O. Box 405, Charlotte Hall, Maryland 20622 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 17 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Charles Memorial Gardens Leonardtown, Maryland 30, 2007 21. Sign dur of Funeral Service Licenses 22. Name and Address of Facility Mattingley Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one care immediate Cause (Final disease or condition resulting in death) ue to (or 0 a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? er significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performed r 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death

The law requires that the death certificate be executed for use as the burial-tran Division or Vital Records, P.O. Box 68760. signed by the at d be detached for To the Hospital or Attending Physician: this After death,

after death Director: filled in by the

within 24 hours a

Physician

Examiner

/Medical

Physician

/Medical

Examiner

Funeral Director

Completed by

Be

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Examiner

Completed by Physician/Medical

Be

Medical Certification: To

Funeral

Director

Deprinit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar most home.

Baltimore, Maryland 21215-0036

28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 Could not be

determined

29c. License number

30. Name and address of erson who completed cause of death (Item 23a) (Type, Print)

MARY 31. Date filed (Month, Day, 32. Registrar's Signature

State Registrar

Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)



DHMH 17 Rev 1/2001

WAUACE DIANA 07-02294 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day March 25, 2007 **Medical Examiner** Diana Lynn 1434 hrs Wallace 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Calvert 1395 Gregg Drive Lusby If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) oreign Director July 2, 1958 217-74-7095 CountryMaryland 1 M 2 X F 48 Usual Residence of Decedent á 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 X No or 28a-f show MD Calvert Lusby notified at once. Director 10e. Street and Number 10g Citizen of What Country? 10f. Zip Code 1395 Gregg Drive 20657 USA or items 23a Funera 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, must be 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes White hours after 3 Widowed 4 X Divorced Give Yea Yes 2 X No specify: Specify traumatic event, the Medical Examiner "natural" δ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene. ant: If item 27 is marked other than "1 or other traumatic event, the Medical E College (1-4 or 5+) Baltimore, MD 21215-0036 12 Manager Retail Store 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Thomas Allen Clower Inas Dora Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Inas N. Clower (mother) 895 Caravan Trail Owings, MD 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State crematory or other place Burial 2 X Cremation 3 Removal from State Department o 2007 Lee Crematory Clinton, MD Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, Cary Ja Coff 8125 Southern Maryland Blvd. Owings, MD 20736 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and Medica Death a Acute ethanol and multiple drug (metahdone, morphine, codeine Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Lamotrigine and trazodone) intoxication Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and Physician/Medical X UNPENDED attending physician for use as the burial AMENDED #23a.27.28a-f. g866, 4/9/07 TT perME. Box 68760, JE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Day ned by the attending detached for use as Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. \$ 1 Yes 2 No 3 Probably 4 V Unknown 24a. Was ar 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? page certificate ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) director, Be Other₄ examiner? Hospital: 1 Inpatient 2 DOA Nursing Home 5 Residence 6 V Other: Scene FR/Outpatient 3 1 🗸 Yes ٩ No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natura Yes 2 X No Pending unk the Fnd 3/24/2007 Fnd 2:18 2 Accident Investigation in by 1 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be or Town, State) 1395 Gregg Dr. Lusby, MD determined house Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi within 2 To the I

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

MAR 3 0 200 State MAR Registra

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month. Day Year)

March 26, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 1:40 A M Ashley Gilbert Dean Acril 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Woodbine 5906 Woodbine Road If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Months 1 → M 2 □ F 67 219-34-1107 Dec 30 1939 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ➡No Woodbine Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code US 21797 5906 Woodbine Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shipping Clerk/Weight Master Stone Quarry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roy Smith Ashley Roten Marie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21797 5906 Woodbine Road, Woodbine, MD Lauretta Ashley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) Lake View Memorial Pk Apr 9 2007 | Sykesville, MD 21. Sign ture of Funeral Service Lice Purrier-Queen Funeral Home 1212 W. Old Liberty Rd., Winfield, MD 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death e Cause (Final tastanc Sophageal veek disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2X No 3 Probably 4 Unknown 1 Tes

Physician /Medical Examiner

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To the Funeral Director: After th completely filled in by the funeral

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Physician

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Completed

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Director

27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

72 hours after

d 2 should be filed within 7% th and Mental Hygiene. 7 is marked other than "ns

Pages 1 and 2 s ment of Health an ant: If item 27 is 1

3altimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner that initiated events resulting in death) Last Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performe 1∐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day

and manner stated

28b. Time of 28c. Injury at Work?

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
Injury_at 28d. Describe how injury occurred

1 Natural 5 Pending investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

26. Place of Death (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OOPER 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registre 1-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 8:20 AM ivia mon 2007 /Medical 4a. Facility Name (If not institution, give street and number)

S + A GNL S Hea 4b. City, Town, or Location of Death 4c. County of Death Examiner 1th Care Timore If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days 212-60-5448 Months Hours 1 □ M 2 💢 F Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 77 is marked other then "natural", or items 23a or 28e-f show traumatic event, <u>the Medical Examinar must be notified at</u> MD 3altimore 1 Yes 2 No by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 229 21 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: Blac 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. QO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondar (0-12)College (1-4or 5+) omestic 24 omestic Eather's Name (First Aiddle, Last) Mother's Name (First, Middle: Maiden Sarname) ver 19b. Mailing Address (Street and Number or Health a importent: if item 2 any injury or other once. 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Meadow 21. Signa re Fundal Service Disensee Funeral Services 23a. Part. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) arler CORONARY **Physician** /Medical Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospitel or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ension been sic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D⊌nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t lirector, page 2 s autopsy performe 1 Yes 1 ☐ Yes 2 No 2 X No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 Yo 2 R/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Satural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funaral Director: completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

APR 0 9 2007

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

530 S

ST, Agnes

00054558

Physician

TRIMO

A. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RKe

Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 07:07 Pm FRANK BARTUCCA 04-06-2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPICE OF BALTIMORE GILCHRIST CENTER TOWSON BALTIMORE 8. Date of Birth (Month, Day, Year) 08-21-1916 5. Social Security Number 6. Sex **XX** M 2□ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Days Hours 90 233-14-1902 **VIRGINIA** Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits BALTIMORE MD. LUTHERVILLE - TIMONIUM 1 ☐ Yes 2XXNo 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 215 BELMONT FOREST COURT 21093 U. S. A. 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 XX Yes 2 □ No If Yes, Give Year or Dates: W.W.II 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify WHITE Specify: XX Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RETAIL SALES MANAGER YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DOMINICO **BARTUCCA** FRANGIPAME **AIDRUVA** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES B. BARTUCCA 18 CLUB VIEW LANE, PHOENIX, MARYLAND, 21131 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 04-09-2007 TOWSON, MARYLAND, 21204 1050 YORK ROAD TOWSON, MD. 21204 Approximate Interval Between Onset and Death YCars Year 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Tother (Specify) HOSPICE 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar			State	of Maryla	nd / Depa	artmen rtificat			and M	•	giene	$Z \cup U \cup I$	11096
	_		Decedent's Name	(First, Middle	Last)								2. Date of De		•	3. Time of Death
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**	/Medic		4a. Facility Name (If						4b. City.	Town, or	Location of		APLII		County of Deat	
7	Examin	ier	Westlie								re (n/a	
	Funeval		5. Social Security N		6. Sex	ring		s. last birthday)			If Under		8. Date of Bir	th	0 Rie	hplace (State or Foreign
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215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Completed	/Snoo	15. Decedent	s Educa	tion	1	16a. Dece	dent's Usua kind of wo	al Occupa	ation	t of work	ina	16b. K	ind of Business/	Industry
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na	me/Relationsh	ip <i>(Type</i>	e. Print)		19b. Maili	ng Address	(Street a	and Numb	er or Run	al Route Numb	er, City o	or Town, State, 2	Zip Code)
	alth alth 27 l		Charles	F. Be	eatt	y /	Son	177	Kenv	vood	Roa	ıd,	Pasade	ena,	MD 21	.122
Baltimore,	s 1 s of He Item		20a. Method of Disp				I	. Place of Dispo	sition (Nar	ne of	e) !	(Date	20c. Lo	ocation - City or	Town, State
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	ires tha signed I be det	by	Part II. Other signif	icant conditio	ns contr	ibuting to	death but not r	esulling in the u	паепуна с	ause give	en in Pari				,	the cause of death?
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	o hir th	Me	29b. Signature and	title of certifier					290	c. License				29d. Da	ite signed (Mont	th, Day, Year)
	7		> Que	puro	ch	MD				Dia	619	ŕ		AL	ril 5,	2007
, ×			30. Name and addr	ess of nerson	who com	pleted oa	ise of death /It	em 23a) /Tuno	Print)							
1)		C.VERG				9940	FRANK	UN .	Sam	ARE	DR -	BALTI	MOR	6, MD .=	21236
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 _ State	State of Maryland	•	artment of H r <i>tificate of L</i>			iene _{eg. No.} 2 (107	11197
			Registrar Decedent's Name (First, Middle, Last)			inioato o. a		2. Date of Dear	th		3. Time of Death
	Physicia /Medic		Rose	Bluefeld				April	04 2	Year	0645AM
	Examin		4a. Facility Name (If not institution, give st	1 -4:1			Location of Death		4c. County	of Death	
		ž	7219 Park Height.			13clT	imore If Under 24 Hrs.	9. Date of Birth	N/A	O Dist	(2)
	Funeral Director		214-01-4960	7. Age (In yrs. la	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day) 07/28/1	, Year)	9. Birthp Cour	place (State or Foreign htry)
	land ow f		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	Mary -f sho fied a	tor	MD N/A	BAL	TIMORE						1 XYes 2 No
	or 28a	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of \	What Cour	ntry?
	death with the Maryland ms 23a or 28a-f show r must be notified at		7219 PARK HEIGHTS	AVENUE, #402	2	2120)8			SA	
2-0036	be filed within 72 hours after death with the Marylan d ablygiene. d they tian "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2□ Married 3 ☒ Widowed 4□ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2(X) No	spanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - Americ ck, White, /: WH]	etc.
ה	72 h "natu dical	etec	15. Decedent's Educa (Specify only highest grade	ation completed)	16a. Deced (Give	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of worki	ing	16b. Kind of B	usiness/Ind	dustry
7	within iene. than " the Mec	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired RING)		FUUD	SERV	ICE
7 0	Hygie Hygie Sther	ပိ	17. Father's Name (First, Middle, Last)		OATE	INTING	18. Mother's Name	e (First, Middle, i			ICL
lal	should be id Mental marked o	To Be	ISRAEL	Pl	LEET		LENA			HOLL	AND
ary	2 sa ar		19a. Informant's Name/Relationship (Type	*	19b. Mailir	ng Address (Street a	and Number or Rura	al Route Numbe	r, City or Town,	State, Zip	Code)
<u>~</u> `	1 and 2 Health em 27 i		SHEILA JACOBSON / [BROOKMILL				212	
Saltimore	permit. Pages 1 a Department of Hee Important: If Item any injury or othe		20a. Method of Disposition 1	moval from State	emetery, crer	osition (Name of matory or other place OUNG MENS	e) !		BALTII		
Dall	permit Depart Import any inj once.	t 30	21. Signature of Funeral Service Licens	Miger		2. Name and Addres	201	LEVINS			INC. MD 21208
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations the death caused the death cause of each line. Metastatic					rest,		Approximate Interval Between Onset and Death NonThS
	/Medical Examiner		resulting in death)	Due to (or as a consequ							
	uted	Examiner	Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse ju	ence of						
oo,	certificate be executed iding physician and ise as the burial-transit	al Exa	resulting in death) Last	Due to (or as a consequ	ence of):						
09/90	fficate g phys is the	edical	d.								311
.O. Box	law requires that the death certi as been signed by the attending 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome pf pregnar 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	□Ectopic pregnancy □ Other <i>(specify)</i>				te of delive	ery Day Year
, L	s that	by Pi	Part II. Other significant conditions cont	-	-			23e. Did to	bacco use con	tribute to t	he cause of death?
ecords,	equire en sig ould b	ed k	Breast cancer	Cr	itical	Hurtic	stenosis	1 🗆 Y	es 2⊠No	3 ☐ Prot	pably 4 □Unknown
vital Reco	: The law r cate has be ; page 2 sh	Completed	Hepatitis C		* down direction			24a. Was a autops perfor 1∐ Yes	sy med?	prior to co death?	ppsy findings available mpletion of cause of
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	sictan certifi rector	Be	25. Was case referred to medical examiner?	ospital:		ot 3 DOA Othe	26. Place of Death				
5	y Physer this eral di	1: To	1 Yes 2 No	28a. Date of Injury	28b. Time o	K 3 DOA	4 🗆 Nursing Ho	me 5 Residence 128d. Describe h			(y)
VISION	ath. r: Afte le fun	atior	1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Injury		Yes 2 □ No				
DIVIS	al or Atte s after des il Directo ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hos building, etc. (Specify		reet, factory, office		28f. Location (S City or Tow		per or Rum	al Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical (29a. Certifier 1	cian: To the best of my knower: On the basis of examinat and manner stated.	vledge, deat ion and/or in	h occurred at the tin vestigation, in my o	me, date and place, pinion, death occur	and due to the or	cause(s) and m date and place,	anner as s and due t	stated. o the cause(s)
	To the Comp	Š	29b. Signature and title of certifier	0. 0		29c. License		2	29d. Date signe	d (Month,	
	4		Dloggen	mo			32844		April	04	2007
6			30. Name and address of person who cor DRoggen 5400	old Count /0 32. Registrar's Signat	23a) (Type,	Print) Surte 108	8 Rand	allstow	mo	211	33
K	Sta Registr		31. Date filed (Month, Day, Year) APR 0 9 2	32. Registrar's Signat	ure	books					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year BENJAMIN APRIL 4, BORISH 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Hours Months Days 165-14-0705 87 10/21/1919 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 223 WENDOVER ROAD 21218 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MASTER TOOL MAKER US GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HERMAN BORISH ETHEL **BECK** 19a. Indomant's Name Relationship (Type Print) GAYLE BRIER-BILLEBAULT / 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 223 WENDOVER ROAD, BALTIMORE, MD 21218 DAUGHTER 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State KING DAVID MEMORTAL PARK 1 X Burial 2 □ Cremation 3 □ Removal from State 04/06/2007 | BENSALEM, PA 4 □ Donation /5 □ Other (Specify) 21. Sign fore Funeral Service Lic-22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 That caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest so on each line. 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one carry Approximate Interval Between Onset and Death Immediate Cause (Final 50 CMCER jeans disease or condition resulting in death) Due to (or as a consequence of Due to (or se's consequence of) Due to (or as a consequence of):

Physician /Medical Examiner

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural" or health of the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

physician and s the burial-trans attending p signed by the a Be within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. Medical Certification: To

To the Hospital or Attending Physician; The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4☐Pregnant at time of death

9 Unknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

æ

Part II. Other significant conditions	s contributing to death but not	resulting in the underlyin	ng cause given in	Part I.

1 | Yes 2 | No 3 | Probably 4 | Unknown 24a. Was an

performed? Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No					26. Place of De	ath (Check only one)		
		Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient	3□ [OOA Other: 4 Nursing	Home 5 ☐ Residence	6 Other (Specify)	Hopes
27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	iry occurred	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At building, etc. (Spe	home, farm, stree	et, facto	ory, office	28f. Location (Street a City or Town, Stat		oute Number,

29a.	Certifier (Check only one)

31. Date filed (Month, Day,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

one)	and manner stated.		, and and place, and all to the sales
29b. Signature and title of certifier	1.0	29c. License number	29d. Date signed (Month, Day, Year)

State Registrar

6701 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

(Type, Print) A. Charles St Balts and 21205

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend #8, perFH, 6866, 4/9/07 TT

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year \mathbf{p}^{M} Robert Collins /Medical April 05 2007 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bayview Medical Center Baltimore 5. Social Security Number If Under 1 Yea Date of Birth 9/1/1930 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F Director 220-22-6724 76 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Ex miner must be notifled at 1X Yes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1734 Thomas Avenue U.S.A. 21216 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Metal Molding 8 Truck Driver Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Collins Priscilla Brooks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby L. Collins / Wife 1734 Thomas Avenue, Baltimore, Maryland 21216 ce of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Nat'l Ceme. 04/13/2007 Laurel, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Dicensee any 4611 Park Hots. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician INFARCTION AIVIE MYGCIANIAL NHI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any Lading Communication cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed 2 No 1☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1) W7 9 47 6 7667 wn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar MMI) ALIZIM UND

APR 0 9 2007

31. Date filed (Month, Day, Year)

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32 Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 0750 AM 2007 07 April Melvin Dixon Richard /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Sinai Hospital of Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 □ F Mar 7, 1932 Maryland 75 Director 216-30-0152 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location death with the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner. 1 ☐ Yes 2 No Carroll Westminster Director MD 10g, Citizen of What Country? 10f, Zip Code 10e. Street and Number 21157 US 2230 Sams Creek Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after on and Mental Hygiene.
Is marked other than "natural", or iter 1 ☐ Never Married 2 → Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) School / Coca-Cola Bus / Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christina_ 2 Marie_ Dixon William _ Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2230 Sams Creek Rd., Westminster, MD wife Elizabeth W. Dixon Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Apr 11 2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Winfield, MD South Carroll Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burrier-Queen Funeral Home 1212 West Old Liberty Rd., Winfield, MD 21784 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I mediate Cause (Final d. ease of condition re miling in death) Physician Due to (or as a cons quence of): 10 years /Medical Examiner 3 days Ventricular Tactycardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed for use as the bunal-transit Brain Anoxic **J**g Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) s been signed by the s should be detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown Heart Failure Congestive 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has e 2 page certificate Hospital or Attending Physician: : After this certification funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ို 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury 27. Manner of Death Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 060393 April 7 2007 S Bred MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital Steven S. Brooks MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) APR 0 9 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 18:15 " DELLAPENNA APRIL 3 ADENA BEILE 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CITY THE JOHN'S HOPKIN'S HOSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 🔀 F Yrs 84 Director 10-21-1922 212-44-4076 Virginia Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ai Hygiene. I other then "naturel", or fleme 23e or 28e-f show vent, the Medical Expirition plust be notified at 1 Yes 2 No MD n/a Baltimore Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Funerai 301 S. East Avenue 21224 filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In own home 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 end 2 should be fill timent of Heelth and Mental H tent: if item 27 is marked oil William Gillispie Mary Robinson 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 S. East Ave., Baltimore, Maryland 21224 Arlene Kintzel other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of important: if eny injury or once. 4/12/2007 Baltimore, MD 4 □Donation 5 □ Other (Specify) Greenmount 22. Name and Address of Facility Joseph N. Zannino Jr FH 21. Signature of Eugeral Service License 263 S. Conkling St.Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List gary one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1 hour RESPIRATORY ARREST disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): ettending physicien end for use as the burial-transit or Attending Physicien: The law requires thet the death certificate be executed week URINARY TRACT INFECTION that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) cete hes been signed by the cape 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes After this certifice funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending To the Hospital or Attending within 24 hours after deeth.

To the Funeral Director: Afte completely filled in by the fun 1 TYes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28f Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AMIR KASHANI, MEDICAL DOCTUR APRIL 8. 2007 RES-000 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMIR KASHANI, THE JOHNS HOPKING HOPKIN 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

APR 09

2007

DISNEY, CARMel A Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760.

			pe or Print in Black			-	_	
		1 _ State	tate of Maryland / D	epartment of F Certificate of			- 21111/	11102
		Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of		Reg. No.	10 0 0 7	3. Time of Death
Physicia		Carmela R. Disne	∋y .			April 5	2007	11:05 A M
/Medic Examin		4a. Facility Name (If not institution, give street	et and number)		or Location of Death	14	c. County of Death	
		STAGNES	Healthcar	13.	imore			
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs. last birth	hday) If Under 1 Year Months Days	Hours Min. 8	Date of Birth Month Day 03/01/19	10 Ita	olace (State or Foreign ntry) LLY
D		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
Aaryle f sho	ŏ	MD Baltimore		Catonsville				1 Yes 2X No
the P	Director	10e. Street and Number		10f. Zip Code		10g. (Citizen of What Cou	ntry?
th with		2 Rumford Drive #10)4		21228		United S	tates
ems sum	Funerai	11. Marital Status 12.	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Specit an, Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Ameri Black, White,	
permit. Pages 1 and 2 should be filled within 72 hours after deeth with the Marylend Department of Heelith and Mentel Hygiene. In Important: If tiem 27 is marked other then 'natural', or items 23a or 28a-f show any injury or other traumatic event, it a Madical Examinat must be notified at one.	ρ		1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	1 ☐ Yes 2 No	Specify:		Specify: Whi	.te
72 hc	etec	15. Decedent's Education (Specify only highest grade control of the control of th		Decedent's Usual Occup (Give kind of work done	during most of working		Kind of Business/Ir	ndustry
within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire Seamstress	ia)		Factory	
filed Hygie other		17. Father's Name (First, Middle, Last)	1	Dedi. Der CDD	18. Mother's Name (
uld be Aentel rked tic ev	To Be	Guswaldo Gervasi			Natalie I	DiPrima		
shor and h		19a. Informant's Name/Relationship (Type,	•	Mailing Address (Street				
and and mark		Theresa A. LOngo (Rumford Dri Disposition (Name of	.Ve #104, C			
ges 1 if of H or of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remi	oval from State cemeter	y, crematory or other pla	(ce)		Location - City or T	
it. Pa ntmer rtant: njury		4 □ Donation 5 □ Other (Specify) 21. Sprature of Funeral Service Licensee.	Dulane	y Valley 22. Name and Addre	04-10			Le, Maryland
Dep Perm			miden.		ens Avenue	, Baltimo	eral Home, ore, Mary	land 21229
	_	23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one c	ions that caused the death. Do n					Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	PNEUMON	Α;				Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequence of	of):				1. 6
CAdminer	16	Sequentially list conditions, b. —	Due to for as a consequence of	ol):				Jun Kinerius I
ecuted and -transit	camine	cause. Enter Underlying Cause (Disease or injury that initiated eyents						
executing and rial-train	Exa	resulting in death) Last	Due to (or as a consequence of	of):				
The law requires that the death certificate be exite has been signed by the ettending physician a bage 2 should be detached for use as the burial-	ical	d. =						
artifica ling pt e as t	Med	IF FEMALE:	War 200 Annua - Annua					
ath cer ettendin for use	Physician/Medical	23b. Was decedent pregnant	If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death	3 Ectopic pregnanc	ry .		23d. Date of deliv Month	ery Day Year
t the de by the c	iysic		9 Unknown	3 Cities (specify)				
s that the ned by a detact	by Pt	Part II. Other significant conditions contrib	outing to death but not resulting in	the underlying cause gr	ven in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
w requires been sign should be		Asthma.				1 🗆 Yes	2 □ No 3 □ Pro	bably 4 Unknown
law reas becase 2 sho	Completed					24a. Was an autopsy	24b. Were aut	opsy findings available empletion of cause of
	E OC					performed? 1 ☐ Yes 2 ☐	? death?	2000
sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	oital:	Ott	26. Place of Death (
Phys this aldii	5.T	TO THE ZERNO	1 ☐ Inpatient 2 X ER/Out 28a. Date of Injury 28b. T	ipatient 3 DOA	4 Nursing Home	5 Residence d. Describe how in	6 ☐Other (Speci	fy)
tending later. tor: After the funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Ir	ime of 28c. Injury Wo	rk?]Yes 2∐No			
To the Hospital or Attandi within 24 hours after deeth. To the Funarel Director: A completely filled in by the fu	Certification:	2 Could not be	28e. Place of Injury - At home, lar building, etc. (Specify)	rm, street, factory, office	28	Location (Street City or Town, Sta	and Number or Rui	al Route Number,
Hospital or 24 hours afte Funaral Dir tely filled in I								
Hosp 24 hou Funa tely fi	edicai		 en: To the best of my knowledge On the basis of examination and and manner stated. 					
ro the vithin 2 Fo the complete	Med	29b. Signature and title of certifier		29c. Licen:	se number	29d. [Date signed (Month,	Day, Year)
⊢≯⊢ŏ		D R M	2 Physici	AN DOO	SYSSA	A	PRIL 5.	2007
		30. Name and address of person who comp	eleted cause of death (Item 23a) (Type, Print)	1 7 1			
2		HEDERICK BUN	Ce, Je, uno St.	29c. Licen: D 00 Type, Print) A 1 Ne 5	TOSPILAL	, SA /tir	nore, m	1).
Sta Registr		31. Date filed (Month, Pre Year) 200	7 32 Registrar's Signature	A PARTICION OF THE PROPERTY OF				

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Maryland / [nd Mental Hy	/giene)			
			Registrar 1. Decedent's Name (First, Middle, I			Certific	cate of	Death	0.0-1-10	Reg. No.	2007	-1110		
7	Physici /Medi		Linwood	E.	Dil	lard		Jr.	2. Date of Dominion Month	Day		3. Time of Death		
)	Examir	ner	4a. Facility Name (If not institution, g		per)	4b.		or Location of I	Death	4c.	County of Death			
40,	Funeral	-	Gilchrist Center 5. Social Security Number 6.		Age (In yrs. last bir	thdav) If U	TOWSO	If Under 24	Hrs. 8. Date of Bi	rth				
200	Director		216-28-8449	X M 2□F			ths Days	Hours	Min. 8. Date of Bi (Month, Di			place (State or Foreign ntry) cimore, MD.		
	land ow tt		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits		
	a-f sh	ctor	Maryland Baltim	ore	Dune	dalk						1 □ Yes 2 □ No		
	3a or 28	Funeral Director	10e. Street and Number 2023 Kelmore Road	đ		10f. Zip Code 21222						10g. Citizen of What Country? USA		
	ems 2	iner	11. Marital Status	12. Was Decede		13. Was D	ecedent of F	lispanic Origir	n? (Specify Yes or No Puerto Rican, etc.)	0-	14. Race - Ameri Black, White,			
5-0036	be filed within 72 hours after death with the Maryland Hygiene. od other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced		□No	i	es 2 🛣 No	Specify:	deno moan, etc.,			ite		
15-0	in 72 ho "natu ledical	Completed	15. Decedent's (Specify only highest g	rade completed)		Decedent's (Give kind of life, DO NO	Usual Occup If work done OT use retire	oation during most o d)	f working	16b. Ki	ind of Business/Ir	dustry		
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nd	2 should be filed and Mental Hygi Is marked other aumatic event, t	Be C	17. Father's Name (First, Middle, La.	st)				18. Mother's	Name (First, Middle	,	Surname)			
<u> </u>	should be and Mental marked o	2	Linwood E. Dillar						e Persone					
Ž	# 23 m		19a. Informant's Name/Relationship Jeanette Dillard	(Type. Print) Wife					or Rural Route Numb Dundalk, Ma			o Code)		
o e	Pages 1 ar nent of Hea int: If Item 3 iry or other		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3		20b. Place of cemeter Sacred	Disposition y, crematory	(Name of or other pla	ce) A	pril 11,		ocation - City or T	own, State		
Ħ	permit. Pages Department of Important: If It any Injury or o		4 ☐ Donation 5 ☐ Other (Special Signature of Fungral Service Lice		- Sacred			: :	2007		dalk,MD.	- ····		
ñ	Dep Imp any		Enthony	Con	nelly,	7110	elly E Solle	Tuneral ers Poi	. Home Of .nt Road,	Dunda Dunda	alk,P.A. alk,Md.	21222		
é			23a. P. rt1. Enter the disease, or of shock, or heart failure. List of	mplications that cau y one cause on eac	sed the death. Dor							Approximate Interval Between		
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	/Medical Examiner	her	resulting in death)	Due to (or	as a consequence of	of):								
			Sequentially list conditions, if any, leading to immediate	b Due to (or	as a consequence of	of):								
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	ificate g phys as the	edical		d										
ROX	law requires that the death certifi as been signed by the attending t 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me pf pregnancy h 2 Fetal death	3∏Ector	ic pregnancy	/		2	23d. Date of deliv			
	ne dea the att hed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nt at time of death		r (specify)				Month	Day Year		
7	that the		Part II. Other significant conditions	contributing to deat	h but not resulting in	the underlyi	ng cause giv	en in Part I.	23e. Did	tobacco u	ise contribute to t	he cause of death?		
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_	his ldir	- To	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inp			DOA Oth	4 LI Nursi	ng Home 5 ☐ Resi			n Hospice		
0	nding Ph th. : After th e funeral	ıtion	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month,		jury M	28c. Injur Wor 1 🔲	k? Yes 2 ∐ No		now injury	y occurred			
DIVISION	after death after death Director: / d in by the f	Certification:	3 Suicide 6 Could not 4 Homicide determine	20e. Place of	injury - At home, far , etc. <i>(Specify)</i>	m, street, fa	ctory, office		28f. Location (City or To	Street and wn, State	d Number or Rura	al Route Number,		
ָׁב	pital c		20a Cartifiar 1 Cartifulna I	Physicians To the he	act of my knowledge	dooth again	erod of the att							
į	Io the Hospital or Attending P within 24 hours after death. To the Funeral Director: After to completely filled in by the funera	Medical	29a. Certifier (Check only one) Certifying F	mysician: To the beasi aminer: On the basi and manner	s of examination and	death occu I/or investiga	ation, in my o	ne, date and popinion, death	place, and due to the occurred at the time.	cause(s) , date and	and manner as s I place, and due t	tated. o the cause(s)		
1	To th To th comp	Me	29b. Signature and title of certifier	0			29c. Licens				e signed (Month,			
)			pron (Sac	& ino			1000	51199		April	, 8, 200	7		
	0		30. Name and address of person who	completed cause of	of death (Item 23a) (Type, Print)	1.10	109 7	man w	d '	21204			

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. A gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 00:07 AM LORRAINE DAVIS PRII 2007 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death UNION MEMORIALM HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 075-38-4008 **Director** 60 10-27-1946 FLUsual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Items 23a or 28a-f show ner must be notified at 1 ▼Yes 2 □ No Director MD HARFORD **EDGEWOOD** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with "natural", or Items 23a 327 REDBUD ROAD 21040 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than "r traumatic event ** Elementary/Secondary (0-12) College (1-4or 5+) TEACHER'S AIDE **EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be timent of Health and Menta tant: If item 27 is marked jury or other traumatic en JAMES EDWARD HALL HAZEL B. STARKES ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEE DAVIS/HUSBAND 327 REDBUD RAOD EDGEWOOD, MARYLAND 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of I Important: If its any injury or o 1 N Burial 2 ☐ Cremation 3 N Removal from State 4-13-2007 ROCHESTER, NEW YORK GROVE PLACE CEMETERY □ Donation 5 □ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS FUNERAL HOM 1701 LAUREENS ST., BALTIMOREE, MD 21217 Part . Finer the diffease, or compliciting is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only the cause whach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Severe AORTIC STENOSIS years /Medical Due to (or as a consequence of): Examiner CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 ☐ Other (specify) Day 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed END-STACE REWAL DISEASE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an CONGESTIVE HEART page 2 s autopsy performed Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

Registrar

14

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University PKWY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MemoRIAL

Union

Hospital

32. Registrar's Signature

AT 2438946 APRIL 6th 2007 JENNIFER NOZNITSKY Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes of the State of Maryland / Department of Health and Mental Hygienes of the State of Maryland / Department of Health and Mental Hygienes of the State of Maryland / Department of Health and Mental Hygienes of the State of Maryland / Department of Health and Mental Hygienes of the State of Maryland / Department of Health and Mental Hygienes of the State of the S

			for State Registrar	State of	of Marylan		artment of rtificate o		nd Ment	al Hygie Reg.	201	7	11105
42			1. Decedent's Name (First, Midd	le, Last)						ate of Death	Day		3. Time of Death
	Physici /Medi		James V. Diehl	, Sr.						oril 5.	Day 2007	Year	4:30P ^M
	Examir		4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City, Town	n, or Location of			4c. County o	f Death	1 1301
			Collingswood	Nursing	Center		Rockv:	ille			Monta	come	rv
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye Months Day		24 Hrs. 8. Da Min. (A	ate of Birth			lace (State or Foreign
154.1	Director		206-05-0120	1	88	Yrs.	Wioritis Day	ys Hours	Dec	Month, Day, Ye	1918	Penn	isylvania
+	pu ,		Usual Residence of Decedent		100 00	T	41						
	anyla shov d at	-	10a. State 10b. County		100.010	ty, Town or Lo	cation					1	0d. Inside City Limits
	8a-f	Sct		ette	Lake	Lynn							1 ☐ Yes 2 ☑ No
	vith ti	Director	10e. Street and Number				10f. Zip Code	е		10g.	. Citizen of Wh	nat Coun	try?
	in 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show satical Examiner must be notified at	Funeral	253 Blosser Hil				15451	-		Un	ited S		_
	tems	une	11. Marital Status	Armed F		.S. 13.	Was Decedent of If Yes, specify C	of Hispanic Ongi uban, Mexican,	in? (Specify Y Puerto Rican	es or No- , etc.)	14. Race Black	 America White, e 	
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Baltimore,	+ 유명구		4 □ Donation 5 □ Other (S		Ever	-	emorial P		2007		int Man	rion	, Pennsylvani
Ba	permi Depar Impo any it		21. Signature of Pulleral Service	Cicensee	MOOO	Ro	bert A. P	umphrey F	uneral H	Iome/Bet	hesda-Ch	evy (Chase, Inc.
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			23a. Part1. Enter the dise se, or shock, or hear failur. List	only one cause on	each line.	n. Do not ent	er the mode of c	iying, such as ca	ardiac or resp	oratory arrest,			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Figure disease or condition resulting in death)		1 Fibri		n					- 1	months
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ō	교 후 등	၉	1 ☐ Yes 2 ☑ No 27. Manner of Death			ER/Outpatient	1 3 DOA			Residence)
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7	١, , ١	-						3430		Ap	ril 6,	200	7
	1241		30. Name and address of person					U n . c . m	_				
	3 01		Gaurang K. Tha	32 F	3411 (legistrar's Signat	JLAndwo ture	od Ct.	#105 , 0	lney,	Maryla	nd 208	32	
	Sta Registr			9 2007	i a a	M. A	rock D						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 6, , Day 2007 ear Harriet Ann England 11:00A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11610 Red Run Boulevard Reisterstown Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Country) | 9. Birthpl 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 1 □ M X2X F 215-42-0162 66 Yrs Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes XXNo MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11610 Red Run Boulevard 21136 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes XXNo If Yes, Give Year or Dates: 1 Never Married XX Married 1 ☐ Yes XX No Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Milton Hanna Helena Elizabeth Rothenberger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George C. England / Husband 11610 Red Run B1vd.; Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State All Saints Cemetery 4/10/07 4 ☐ Donation Other (Specify) Reisterstown, MD 21. Signature Fretal Service License 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. val Between et and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause. Unlease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregna

Physician /Medical Examiner

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Physician

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Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Examine Physician/Medical þ Completed Be ٩ Certification:

27

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed to thours after death

Division or Vital Records, P.O. Box 68760,

. List o	only one cause on each line.	Inter
1	a	
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ınt ?	23c. If yes, outcome pf pregnancy 1	23d. Date of delivery Month Day
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in the past 12 mod 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

			ntribute to the cau	
	2		3 ☐ Probably	
24a. Was an autopsy performed?	?/	24b.	Were autopsy fir prior to completi death?	ndings available on of cause of

Year

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дΗ	ome	5 Resi	dence	6 🗆	Other (Speci	ify)
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examiner?	26. Place of Death Check only one							
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA	Other: 4 Nursing	Home	5 Residence	6 □Other (Specify)	
7. Manper of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d.	Describe how inju	ury occurred	

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

29a. Certifier (Check only one)	 Certifying Physician: To the best of my knowled Medical Examiner: On the basis of examination a and manner stated. 	ge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature 29d. Date signed (Month. Dav. Year)

cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed

OWNES MILLS, 200 21117 TOWALD 20 CHOSS ROADS DRIVE #290 J77 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Registrar DHMH 17 Rev 1/2001

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Year)

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARBOR MARINA BORODKINA 3001 S. HANOVER STREE 32 Registrar's Signature

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April 5

HOSPITAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2007 Month **Physician** Martha Eberhart Frey April 6, 10:37 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore 6 Saint Elmo Court Apt 2 Cockeysville If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Dec 2, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days 1949 1 M 2 X F Maryland 57 Dec. 216-46-4970 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Cockeysville Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21030 USA 6 Saint Elmo Court Apt 2 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Administrative Assistant Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Lazetta Eberhart Robert Ketterman Frey ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: if Item 27 is n any Injury or other traun once. 704 Dryden Drive; Baltimore, Maryland 21229 Ruth L. Frey Sister 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery 4/11/2007 Woodlawn, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Sen ice Licence Funeral Home of Catonsville, Inc. M01290 23a. Part1. Enter the Isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear ailure. List only one cause on each line. Immediate Caus (Final disease or condition resulting in death) a. CARDIAC DEATH 1630 Edmondson Avenue; Catonsville, Approximate Interval Between Onset and Death minutes Due to (or as a consequence of): DISEASE CARDIOVASCULAR Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of) Examine HTN Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≽</u> ADDISON'S DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed

Physician /Medical Examiner

72 hours after

d 2 should be filed within 7. th and Mental Hygiene. 7 Is marked other than "n.

3altimore, Maryland 21215-0036

the burial-tran Po been signed by the should be detached page 2 certificate director After within 24 hours after death

To the Funeral Director:
completely filled in by the

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Medical Certification:

The law requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

To the Hospital or Attending Physician:

VARIABILITY 24a. Was an ELECTROLYTE autopsy performed? NEURALGIA 1 Yes 2 No 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity) 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

mo

APR 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TO 2502 MD OSLER DR 21204 BOERSMA 7505 31. Date filed (Month, Day, Year)

1)40048

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** Month Year -DITH CIRMY 7007 /Medical PRIL 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner RANDA (15 TO CENTER If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F Director 215-18-8756 16,1925 Feb. Maryland Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe of "natural", or items 23a 959 Shirley Manor Road by Funeral 21136 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after on nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or iter Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 Divorced White the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Caterer Food Catering traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbour Marsh Lucy Margaret Grigsby ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3102 Stetson Drive, Finksburg, MD 21048 Wilma Fogler Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 ☐ Donation Lake View Mem. Park 4/6/07 Sykesville, MD 21. Signature of 5 neral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SUSTANED) disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SUSPECTED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as monsequence of) burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the as attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ned by the a 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an CHAPEN TENSOD Yes 2 110 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ 16 Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Impatient 2 ER/Outpatient 3 DOA 27. Mannon f Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide

The law requires that the death certificate be executed or Vital Records, P.O. Box 68760 this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral Division ö

Fo the Hospital

the

Baltimore, Maryland 21215-0036

Certification:

Medical

29a. Certifier

6 ☐ Could not be determined 4 ☐ Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number 29b. Signature and title of certifier

19502

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. CONTUA ORIGNDO 31. Date filed (Month, Day, Year)

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Registrar's Signature

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			For State Registrar	State of Man		epartment of Certificate of			giene 0 0	7 11110
			Decedent's Name (First, Middle, Last)					2. Date of De Month		3. Time of Death
	Physicia /Medic		Mary V	irginia Pf	ister F	inigan		April		12:55 PM
	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town,	or Location of Deatl	h	4c. County of	Death
			Suburban		In In ad blinds	lf Under 1 Year	Bethesda If Under 24 Hrs.	9 Date of Bir		ontgomery Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex	M 200 F	In yrs. last birtho Yrs	Months Davs		(Month, Da	9, 1915	Country) Ohio
			Usual Residence of Decedent					nagust	J, 1/1/	
	inylan show	_	10a. State 10b. County	10	0c. City, Town o	r Location				10d. Inside City Limits 1 ☐ Yes 2 🖔 No
	ith the Marylan or 28e-f ehow	Director	Maryland Montgo	omery			Bethesda		10g. Citizen of Wh	
	death with the Maryland ms 23a or 28e-f ehow		10e. Street and Number			10f. Zip Code	20052			
	leath	Funeral	10301 Grosveno	2. Was Decedent Eve	1003 er in U.S.	13. Was Decedent of If Yes, specify Cui	20852 Hispanic Origin? (S	pecify Yes or No		ed States American Indian,
ထ	or Iter		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		If Yes, specify Cui		o Hican, etc.)	Specify:	White, etc.
5-0036	urel', c	d by	3 A Widowed 4 ☐ Divorced	Year or Dates:						White
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ıları	uld be Aenta rked tic ev	To B	Charles	Hurless H	Hi11			Grace E	lizabeth	A1t
Maryland 2121	2 sho and h is ma		19a. Informant's Name/Relationship (Typ	e, Print)		lailing Address (Stree				
. ≥	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28e-f ehov other treumatic event, the Medical Examiner out by notified at		Cynthia P. William	s/ Daughte		2.0. Box 5	98 Flint	Hill, V		2527 ity or Town, State
altimore,	permit. Pages 1 am Department of Heall Importent: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		cemetery. MO:	crematory or other pl ntgomery	ace)	April		.000
Ħ	it. Pa intmer intent njuny		 4 □ Donation 5 □ Other (Specify) 21, Signature of Fuperal Service License 		Crema	torium Inc	ess of Facility RO	. 2007 bert A.	Bethes Pumphrev	da Maryland Funeral Home/ sconsin Avenue
Ва	Depared Important Importan			VII	00335	Bethesda-(Bethesda,	Chevy Char	se, Inc.	7557 Wis	sconsin Avenue
			23a. Part 1. Enter the disease, or complies shock, or heart failure. List only one	ations that caused the						Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as a c	onsequence of)					
3	Examiner	_	Sequentially list conditions, b.	Acute Exac	erbatio	n of Chron	ic Obstru			
inigan	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,					Disease	
h	executed n and ial-transit	Exar	that initiated events c. resulting in death) Last	Coronary A	consequence of)	Jisease				
U. 8760,	be		€ d.							
5 9	certificate be iding physicia ise as the bur	Medi	IF FEMALE:							
yla.	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of p	Fetel death	3 Ectopic pregnan	су		23d. Date Monti	,
< 0.	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at tim 9□Unknown	ne of death	5 ☐ Other (specify)				
ا م	requires that the een signed by th hould be detache		Part II. Other significant conditions cont	ributing to death but r	not resulting in th	ne underlying cause g	iven in Part I.	23e. Did 1	obacco use contrib	oute to the cause of death?
rds	quires n sign lld be	d by	Mild Emphysema & C	hronic Obs	structiv	ve Pulmona	ry Diseas	ie 1□	Yes 2□No 3	Probably 4 Unknown
255 ecords,	law rec as bee 2 shor	Completed	Coronary Artery Di	sease/Stat	tus Post	_Myocardi	a1	24a. Was		ere autopsy findings available or to completion of cause of
Œ	The I	Com	Ī.	ypertensio		•		perfo 1 ☐ Yes	ormed? de	ath? ☐Yes 2☐ No
ارا Vital	cien: ertifica	Bec	25. Was case referred to medical		× 40			ath (Check only		
1	Physicien: r this certific ral director,	ဥ	1 ☐ Yes 2 🔯 No Ho 27. Manner of Death	the same of the same of the same of			ther: 4 Nursing H		dence 6 Other	
5	ding Physicien: The law th. : After this certificate has b funeral director, page 2 sl	tion	1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	<i>(ear)</i> Inju	ry W	ork? ∃Yes 2 □No	250. 20001120	non injury cocurre	
HE Division	Attending ir death. ector: After by the fune	Certification:	3 Suicide 6 Could not be	28e. Place of Injury	- At home, farm	, street, factory, office		28f. Location (City or To	Street and Number	or Rural Route Number,
Ö	el or a	Certi	4 Homicide	building, etc. (<i>Specify)</i>			City of 10	wn, State)	
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 ☐ Certifying Physic (Check only 2 ☐ Medicel Examin	cian: To the best of n	my knowledge, o	leath occurred at the	time, date and place	e, and due to the	cause(s) and mann	ner as stated. id due to the cause(s)
	the H hin 24 the F nplete	Medical	one)	and manner stated	d.		ise number			(Month, Day, Year)
	To vity		29b. Signature and title of certifier	201-	20710	61000		2	1,15	107
	12	-	30. Name and address of person who con				00.0		011)	V 1
	0		Sima Nourani-Zeni			Georgetov	m Road Re	ethesda.	Marylano	1 20814
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's		Rosalle)			<i>J</i>	
	Registr	ar	APR 0 9 20	11 A 35 045	and the same	The same of the sa				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death p 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5:45 M HOR/L **Physician** 2007 G. Germershausen /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2**X**F Maryland 31. 1922 Director 217-14-2679 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show ral", or items 23a or 28a-f shov Examiner must be notified at 1 Tyes 2 No Director Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 2160 Poplar Ridge Road 21122 American Indian, death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No 21215-0036 Specify þ 3 Widowed 4 Divorced White "natural", 16b. Kind of Business/Industry Completed permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home N/AHomemaker 18. Mother's Name (First, Middle, Maiden Surname) Saltimore, Maryland 17. Father's Name (First, Middle, Last) Be Walter ပ Beksinski Katherine 19a. Informant's Name/Relationship (Type. Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2160 Poplar Ridge Rd. Pasadena, Maryland 21122 Ferdinand W. Germershausen, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville V.A. Cem. 4/9/07_ Crownsville Maryland 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final La NICER Physician QY disease or condition resulting in death) /Medical Due to fr as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Line, Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 🛣 No 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy perform 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Date of Injury (Month, Day Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. ours after death.

neral Director: A
filled in by the fu 2 Accident Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Ken NO MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Washington al 17 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			•	State of Maryland / Department of Health and 1- State Registrar Certificate of Death	Mentai	Hygien	6001	11112
		sicia	-	1. Decedent's Name (First, Middle, Last)	2. Date Mont	of Death	ay Year	3. Time of Death
		edica Imine	_	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De TO SEPH RICHEY HOSPICE BALTIA	ORE		c. County of Death	A
	Fune Direc			5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 f Under 1 Year If Under 24 H Months Days Hours Mi Usual Residence of Decedent	n. 8. Date MAY	of Birth th, Day, Yea 28,19	9. Birth	place (State or Foreign intry) RGINIA
	deeth with the Maryland		ctor	10a. State 10b. County 10c. City, Town or Location MARVLAND N/A BALTIMO	RE	CIT	y	10d. Inside City Limits 1XX Yes 2 □ No
	eth with th		rai Directo	106. Street and Number 107. Zip Code 212	17		USA.	
ç	JSO urs after dee il', or iteme		by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes 2 No If Yes, Specify Cuban, Mexican, Pu 1 Yes 2 No Specify:	(Specify Yes erto Rican, et	or No- c.)	Black, White	
L	D P D	9	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	vorking		Kind of Business/I	Í
3	be filed winter the other th	event, ille	Be	17. Father's Name (First, Middle, Last) LABORER 18. Mother's N	lame (First, A			
	Maryland Id 2 should be file Ith and Mental Hy It is marked oth	ranuanc	<u>٩</u>	HENRY 19a. Informant's Ime/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Informant's Ime/Relationship (Type, Print)	(4)		or Town, State, Z	ENE ip Code)), 21217
		y or other		LAIRAE, MELVIN-HODGE (WIFE) \$3 CLIFTON AV 20a. Method of Disposition 1 ☑ Burnal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Date	20c.	Location - City or ALTI HOR	Town, State
=	Baltimore, permit. Pages 1 a Department of Hea Important: if item	once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fullity Acautelize Clane 23. Name and Address of Fullity Clane 24. Name and Address of Full To	ROWN NAV	JR.	FUNERA	
	Pnysic	ian	()	23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, of heart failure. List only one cause on each line. Implediate Cause (Final rease or condition	liac or respira	tory arrest,		Approximate Interval Between Onset and Death
W	/Medi Exami	ner		Due to (or as a consequence of):				
45am	bu , be executed icien and	I SUBURI	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				
	68 / 6U, filicate be e.	st the buria	Ca	d				
4/4/07	VITAL RECORDS, P.O. BOX 08/0U, sicien: The law requires that the death certificate be executed certificate has been signed by the attending physicien and	ched for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	5		23d. Date of del Month	very Day Year
2	rdS, P quires that n signed b	nd be det	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e	. Did tobacc		the cause of death?
Joseph	HECOTOS, The law requires	page 2 sno	Completed		-	. Was an autopsy performed'	pnor to death?	topsy findings available completion of cause of
	Of VITAL Physician: T	actor.	Be	25. Was case referred to medical examiner?				. /
	On Of A	completely filled in by the funeral director, page	Medical Certification: To	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing			6 Other (Specificry occurred	Hospice
17	DIVISION • Hospital or Attending • 24 hours after deeth. • Funeral Director: Afte	d in by the	Sertifica	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		ation (Street or Town, St	and Number or Ru ate)	ral Route Number,
	the Hoepita nin 24 hours the Funera	pletely fille	edicai (29a. Certifier (check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (check only one) 1. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (check only one)	ace, and due ccurred at the	to the cause time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the To the To the	w o o	Σ	29b. Signature and title of certifier 29c. License number D26880		5	Date signed (Mont.	n, Day, Year)
	2			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ACLVY M. Harvis 300 Arms Auce Success 31. Date filed (Month, Day, Year) 32. Registrar's Signature	3 C B	alt.	21201	mel.
	Re	Stat gistra		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death 200 7 **Physician** 10:33 AM essie /Medical 4a. Facility Name (If not institution, give street and number or Location of Death 4c. County of Death 4b. City. Town Examiner Baltimore 's to If Under 24 Hrs. Date of Birth (Month, Day Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 5 Social Security Number 6. Sex **Funeral** Davs Hours Months -567 1 □ M 2 1 F 82 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or 28e-f shov other than "naturel", or items 23s or 28e-f sho 1 Nes 2 No Completed by Funeral Director timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 542(13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 1 □ Never Married 2 □ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Blac 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colege (1-4or 5+) lechnician VYS permit. Peges 1 and 2 should be file. Deportment of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other treumant. 18. Mother's Name (First, Middle, Maiden Sumame) .Father's Name (First, Middle, Last) Be Mason orris 2 or Town, State, Zip Code) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State 21. Signature of Funeral Service Balton M 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a fine. Immediate Cause (Final Physician disease or condition /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The lew requires that the death certificate be executed burial-transit that initiated events resulting in death) Last signed by the attending physicien and does detached for use as the burial-trai Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) O 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Chknown Deen Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate has 2□ No 20 1 ☐ Yes Attending Physician: funeral director, 25. Was case referred medical 26. Place of Death (Check only on Be examiner' Medical Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify ŏ 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 1 Natural 5 Pending Within 24 hours effer death.

To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not b 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29d. Date signed (Month Day, Year) 29c. License number 29b. Signature and Registrar's Signati

DHMH 17 Rev 1/200

State

Registrar

31. Date filed

BONE.

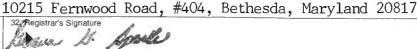
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2007 **Physician** April 4 4:35 Margaret A. Holmberg P^{M} /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Months Days Hours Min 320-42-5089 60 Director Oct. 6, 1946 Minnesota Usual Residence of Decedent ages 1 and 2 should be filed within 72 hours after death with the Maryland nt of Heatht and Mental Hygiene. If ifem 27 is marked other than "natural", or items 23a or 28a-f show confort traumatic event, the Medical Examiner must be notified at 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Montgomery Potomac 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe pe Funeral 6 Colebrook Court 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2**X** No 1 Yes 2 X No þ Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Montgomery County College (1-4or 5+) 5+ Elementary/Secondary (0-12) Teacher Public Schools 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Louis John Adolphsen Margaret Eleanor Zierdt 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once. 6 Colebrook Court, Potomac, Maryland Stevan R. Holmberg/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place Parklawn Memorial 20a. Method of Disposition 20c. Location - City or Town, State April 10, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Chaseda-Chevy 7557 Wisconsin Ave. Rethesda, MD 20814-350 Inc. 23a. Part1. Entit the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate 4 □ Donation 5 □ Other (Specify) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 24 hours Gastrointestinal Hemorrhae /Medical Due to (or as a consequence of) Examiner Aorto-euteric Fistula 24 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Metastatic Adenocarcinoma of Pancreas 18 months Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed? 1⊟ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 M Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 2 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hin 24 hours af the Funeral D npletely filled in 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. To the I 29b. Signature and title of certifie: 29c. License number

yaraare

State Registrar

APR 0 9 2007

George Bolen, M.D. 31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D34069

29d. Date signed (Month, Day, Year)

April 6, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death **Physician** Mary Elizabeth Hamlett 2007 8:40P April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery If Under 24 Hrs. Hours Min. Age (In vrs. last birthday) 1 Year Days **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 💢 F Months 89 577-18-9193 Director March 4, 1918 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐Yes 2XNo Maryland | Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20212 Shipley Terrace 20874 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. à 3 Widowed 4 □ Divorced Specify: Year or Dates White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Clerk Business Retail permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John F. Herrlein Bessie Welch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John C. Hamlett/Son 9423 Penrose Street, Frederick, Maryland 21704 20b. Place of Disposition (Name of Garden of the Pines Garden of the Pines Cemetery crematory or other place)

Cemetery

220. Location - City or Town, State

20c. Location - City or Town, State

20c. Location - City or Town, State

Ocean Pines, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/

Rockville, Inc. 300 West Montgomery Avenue

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/

Rockville, Maryland 20850-2805

Approximate Interval Between 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Cellulitis Lower Extremities Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as Examiner the death certificate be executed physician and the burial-transit Peripheral Vascular Disease Due to (or as a consequence of): Box 68760. Physician/Medical attending p as IF FEMALE 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 Yes 2X No Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrillation 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page certificate 1∐ Yes 2 XNo funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice ို 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury 28h Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation (Month, Day Year) Natural within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Alliams 50 H0058032 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Marke &

D.O.

32. Registrar's Signature

Williams ,

APR 0 9

6001 Muncaster Mill Road, Rockville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2007 Year **Physician** 3, 7:41 A.M April Barbara T. Higgins /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Rockville Montgomery Shady Grove Adventist Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Nov. 29, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🖾 F 1948 Washington, 218-56-2999 58 D.C Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State show at 1 □Yes 2 M No ns 23a or 28a-f sh must be notified Directo Maryland N. Potomac Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with United States 20878 27 is marked other than "natural", or items 23a in traumatic event, the Medical Examiner must b 108 Esworthy Place Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-if Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. e filed within 72 hours after all Hygiene.

other than "natural", or itel 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental I int: if Item 27 is marked or Ruth Sandars Charles Stewart Taylor ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any Injury or other trai 108 Esworthy Place, N. Potomac, Maryland 20878 Dr. John J. Higgins / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 6, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bethesda, Maryland Montgomery Crematorium, Inc. 4 □ Donation 5 □ Other (Specify) 2007 Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service, M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear tailing. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 20 days Physician Multi organ system failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the bunal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Pneumonia Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No ed by the 9□Unknown 9 Unknown been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1□ Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 ☐ No 1 M Inpatient After this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 TYes 2 No M filled in by the fu 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0064502 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Brian

31. Date filed (Month, Day, Year)

CARPENTER, MO

APR 0

DHMH 17 Rev 1/2001

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32. Registrar's Signature

Medical Center Drive, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 30 State of Maryland / Department of Health and Mental Hygiene rar dvr., g866,04/09/07dhb Reg. No. For A State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2007 Month **Physician** March 31, 12:30 AM Norma Merrill Harvey /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Allegany Beverly Living Center Cumberland 8. Date of Birth (Month, Day, Aug 16, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Hours Months Days Min. Maine 1 □ M 2 🔀 F 97 Director 171-28-7612 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2X No Director MD Allegany Cumberland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or 21502 512 Winifred Road USA 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If fleave 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify. Specify: white \$ 3X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk registered nurse healthercare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert Leonard Merrill Helen Myla Stockman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39 Greene Street Cumberland, Wesley McKee/attorney MD21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3 ☐Removal from State 1 ☐ Burial 2 ☐ Cremation 4 Donation 5 Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service License ector Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Ar tery Onset and Death Immediate Cause (Final disease or condition resulting in death) ropable 421 Lovonary **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed physician and the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical as IF FEMALE . If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. After this certificate has been signed by the funeral director, page 2 should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 22 No 2□ No 1 ☐ Yes 1∐ Yes e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and that of certifier D0033286 200 Workch 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunil K. Gupta, M.D., Beverly Living Ctr 31. Date filed (Month, Day, Year) APR 0 9 2007 32. Registrar's Signature State Registrar

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Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 302 AM KWOCH April 3,00 JOSEPH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** altimore City Hopkins Hospital

6. Sex 7. Age (In yrs. låst birthday) Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Min 1**∑**M 2□ F February 16,1942 Maryland 215-40-8767 65 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7345 Manchester Road 21222-1322 Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 TYYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: White ģ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) is marked other than Draftsmen BGE 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental b Stephen Kmoch Mary Franciszkowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra 7345 Manchester Road, Dundalk, Maryland 21222 Brigid Kmoch wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 9. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus 2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21. Signature of Funeral Service Licenses 21222 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or shock, or heart failure. Immediate Cause (Final 10 hows GRAM NEGATIVE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 2 Days PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 1 month Examiner The law requires that the death certificate be executed s ystem LYMPHOMA NERVOUS CEMTRAL that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): Box 68760, physician s the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? I or Attending F after death. 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No nours after death.

neral Director: A
filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours at To the Funeral C completely filled i Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4PRIL 5, 2007 RES -000 MOSI BENNETT 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOSI BENNETT THE JOHN HOPRINS HOSPITAL, 600 NUEM WOLFE STREET, BACTIMORE MARRIAND 11287 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 09 Registrar

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/Medical Examiner use as the burial-tran Box 68760. physician pe attending p signed by the a d be detached for Ö ۵ Division or Vital Records, neec page funeral director, this

Examine Physician/Medical 2 Completed Be Certification:

Physician

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7 is marked other than "natural", or Items 23a or 28a-f st traumatic event, the Medical Examiner must be notified

72 hours after

is 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than "

permit. Pages 1
Department of H
Important: If Itel
any Injury or oth

Physician

3altimore, Maryland 21215-0036

25. Was case referred to medical examiner's 1⊠Yes 2⊟ No

29a. Certifier

(Check only

27. Manner of Death 1 X Natural 5 Pending 2 Accident 3 Suicide 4 Homicide

investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

29b. Signature and title of certifie

29c. License number MI

29d. Date signed (Month, Day, Year) April 4, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4550 Montgomery Avenue #733N, Bethesda, Maryland 20814 Christopher J. Duke, M.D.

State Registrar 31. Date filed (Month, Day, Year) APR 0 9 2007



and manner stated.



To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fu

death.

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James Father Lys	1	- For State Registrar	State of Maryland	•	rtificate of		ia micire		teg. No.		7
Physician	1/	 Decedent's Name (First, N 	Middle,Last) Cick Lysinger					2. Date of Dea Month	Day	Year	3. Time of Death 1739 hrs
Medical Examin		4a. Facility Name (if not insti	tution, give street and number	-)		b. City, Town, o		April 2, 20	4c. Cour	nty of Death	1,001110
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Marnell Hygiera Matural", or items 23a or 28a-f sho important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-				ost of working lif	e. DO NOT u	use retired)	Reta	1	
OO3 withir withir been been been been been been been bee	틹	17. Father's Name (First, Mic	ddle Last)		rian	ager ———	18.Mother's	s Name (First, Middle,			·
215- 215- 22	Be	Glenn R. Lys					De1d	ores J. Mc.	Ateer		
21 hould the is mar	2	19a. Informant's Name/Relat			4			ber or Rural Route Nu			1
, ME and 2 s ealth a em 27 traum	ŀ	Barbara Lyt1 20a Method of Disposition	e Sist	20b.	Place of Dispos	tion (Name of c		Altoona,		<u>rlvani</u> on - City or	
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altin mit. P. partme portan ury or	ŀ	4 Donation 5 Other 21. Signature of Fundamental Signature of Fundamental Signature (State of Fundamental Signature of Sign	vice Liponiee								
	⋠	21. Store of Fund Survice Livree 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, M 23a. Part I. Enter in disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart									MD 21228 Approximate Interval
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Examiner		Immediate Cause (Final disc or condition resulting in dea	th) Due to (or as a con	sequence o	of):						
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of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial - transit	Medical	XUNPENDED	AMENDED b,	27, pe	rME, g866	, 4/10/07	TT				
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Box 687 e death certific the attending p	Physician/	past 12 months?	4 Pregnant	at time of d	=	her (Specify)					
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ords v requir	Completed							24a. Was	psy	prior to o	topsy findings available completion of cause of
Recc The lav	mo:	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes									
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of V og Phys Rer thi	٤	1 Yes 2 No 27. Manner of Death	28a. Date of Ir (Month, Day		28b. Time of I		jury at Work	? 28d. Describe	how injury oc	curred	
ion trendin leath tor: A	atio	1 X Natural 5 2 Accident	Pending Investigation				Yes 2		(O)		real Pouto Number City
Division of Vital Records, P.O ral or Attending Physician: The law requires that the safter death and Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted in the timeral director, page 2 should be detacted in the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted in the funeral director.	Certification:	3 Suicide 6	Could not be determined (Specify)	Injury - At I	nome, farm, stre	et, factory, office	e building, et	c. 28t. Location or Town,		umber of Ru	ral Route Number, City
hou hou		4 Homicide 29a Certifier (Check only 1 Certifyi	ng Physician: To the best of	my knowle	dge, death occu	red at the time,	date and pla	ace, and due to the car	use(s) and ma	nner as stat	ed.
To the within 2 To the complet	Medical	one) 2 Medica	I Examiner: On the basis of examiner state	amination d	and/or investiga			curred at the time, dat			e cause(s) nth, Day, Year)
	Σ	29b. Signature and title of c	ertifier				nse number		April 3,		mi say, rour
		30. Name and address of po	erson who completed cause o	f death (Ite	m 23a)						
		Laron Locke MD.	Assistant Medical E	xaminer	111 Penr	Street, Bal	timore, M	D 21201			., <u> </u>
Sta	ate	31. Date filed (Month, Day,	(ear) 37 Regist	rar's Signa	ture	KI					

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Janshid Mian, M)

9114 Philadelphia

32. Régistrar's Signature

Dr, Svite 108, Baltinere, MD

21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2007 **Physician** April 4, Elizabeth Moore 0130 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Montgomery Rockville 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 😿 F 183-22-3270 July 11, **Director** 76 1930 Pennsylvania Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f sh must be notified TY□Yes 2□No Directo Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or in Important: If item 27 is marked other than "natural", or items 23a or in Injury or other traumatic event, the Medical Examiner must be none. 20851 1602 Forbes Street United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify. Specify. 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Fisher Regina Nolan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20876 Carol M. Eppard/Daughter 11608 Seneca Forest Circle, Germantown, MD 20b. Place of Disposition (Name of Montgomery Crematory or other place)
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State APRIL 4 ☐ Donation 5 Other (Specify) 7, 2007 Bethesda, Maryland Fumphrey Funeral Home/ Montgomery Avenue 22. Name and Address of Facility Robert A. Pumph Rockville, Inc. 3.0 West Montg Rockville, Maryland 20850-2805 21. Signature of Funeral Service Lib n M00803 Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Emphysema 1 Week /Medical Due to (or as a consequence of): **Examiner** Colon Cancer Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last 3 Months Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sepsis 2 Weeks attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2XXNo 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a Division or Vital Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has trector, page 2 s autopsy performed? Yes 2 XNo 1∏ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death Check only one Hospital: 1 🛮 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 ER/Outpatient 3 DOA after death.
I Director: After this d in by the funeral d 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be To the Hospital or Atter within 24 hours after de:

To the Funeral Directo completely filled in by the 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M64415 April 4, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nimesh Shah, M.D. 9901 Medical Center Drive, Rockville, Maryland 31. Date filed (Month, Day, Year) APR 0 9 2007 3. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

07-02501 Beatrice Melter Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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29b. Signature and title of certifier 29c. License number O.C.M.E. April 2, 2007 30. Name and address of person who completed cause of death item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	be exection and unitial - t	dica	UNPENDED X AMENDED #2. Der	ME. g86	6. 4/9/07 TT /	// #1,perME,	G866, 4/10/0	7 TT	
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29b. Signature and title of certifier 29c. License number O.C.M.E. April 2, 2007 30. Name and address of person who completed cause of death item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	he Hospit in 24 hour he Funer: pletely fill	ပ	29a Certifier 1 Certifying Physician: To the best of	f my knowled	ge, death occurred at the	e time, date and plac y opinion, death occ	ce, and due to the caus	e(s) and manner as state	ed
30. Name and address of person who completed cause of d(ath)ttem 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Store 31. Date filed (Month, Day Year) 32. Registrar's Signature	To I	Med	and manner state	ed					
Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			Theoder M. The	0/1	Rumo	O.C.M.E.		April 2, 2007	
State 31 Date filed (Month, Day Year) 32 Registrar's Signature	8					enn Street, Balt	imore, MD 21201		
	St Regis								

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) MORTERIL DAY 2/2007 09:20AM **Physician** KEITH D. NELSON /Medical 4b. City, Town, or Location of Death 4c. County of Death Baltimore 4a. Facility Name (*If not institution, give street and number)*Saint Joseph Medical Center Examiner If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 09-04-1939 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number Sex XIXIM 2□ F NORTH **Funeral** Days Hours Months DAKOTA 67 535-36-9788 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show "natural", or items 23a or 28a-f shov dical Examiner must be notified at 1 □Yes 2XXVo GLENWOOD MD. HOWARD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21738 U. S. A. 3299 SHARP ROAD Funeral death v 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? XXIYes 2 □ No 1963-If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married XX Married WHITE 1 ☐ Yes 2XX No Specify Specify Baltimore, Maryland 21215-0036 <u>^</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) the Medical Hygiene. College (1-4or 5+) 3 YEARS Elementary/Secondary (0-12) **EMPLOYED** SELF ANTIQUE DEALER marked other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if Item 27 Is marked other any Injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NELSON NELLIE RATH WILLIAM ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ROAD, GLENWOOD, MARYLAND, 21738 3299 SHARP (WIFE) NELSON SHARON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation ★★ ○ Other (Specify) ENTOMBM LAWN MAUSOLEUM 04-10-2007 WOODSTOCK, MD. 21104 **CREST** 1050 YORK ROAD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses R. H. Kur RUCK TOWSON FUNERAL HOME, INC. (R. G. RUTH) TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NON SMALL CELL LUNG CANCER Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): PNEUMONIA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine GRAM POSITIVE SEPSIS or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical attending for use as as IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b Was decedent pregnant 3 □Ectopic pregnancy 1 ☐Live birth 2 Fetal death Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? 2 No 1 TYes 25. Was case referred to medical 26. Place of Death Check onl one Be examiner? Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P After this funeral 28d. Describe how injury occurred Date of Injury (Month, Day 27. Manner of Death 1 Natural 2 Accident 28b. Time of Injury at Work? Certification: Injury 5 Pending М 1 ☐ Yes 2 ☐ No investigation death. within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 ☐ Homicide Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

12+1

State Registrar

Medical

mehla M.0 29c. License number D41410

APRIL

29d. Date signed (Month, Day, Year) 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER P MEHTA. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 M. D.

and manner stated

31. Date filed (Month, Day, Year)

0

29b. Signature and title of clertifier

29a. Certifier

(Check only one)

9



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** PETERSON APRIL 13. 10 PM JOSEPH 03 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL BALTIMORK 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Director 215-74-8055 AUGUST 15,1960 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show must be notified at 1 XYes 2 No Director MD BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ŏ Pages 1 and 2 should be filed within 72 hours after death with 114 CHERRY HILL ROAD 21225 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian or Items 11. Marital Status Black, White, etc. the Medical Examiner 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 PORTER CEDAR HILL CEM. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ **ESAU PETERSON** ADDIE BOYD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau 114 CHERRY HILL RD., BALTO, MD 21225 osition /Name of 20c. Location - City or Town, State ADDIE PETERSON/MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) ZION 04/13/07 BALTO., MD 21. Signature - Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H, INC 1701 LAURENS ST., BALTO., MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PHEUMONI Physician day /Medical Due to (or as a consequence of): Examiner SHOUK SEPTICAEMIC Sequentially list conditions, if any, sawing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physiclan: The law requires that the death certificate be executed ORMAN MULTI and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ALCOHOLISM 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 🔽 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manuer of Death al Director: After the 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) M Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft To the Fu eral Di completely filled in To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 1/2001

3

State

(Check only one)

SUBHASH

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Mc. J.h, MD

APR 0 9 2007

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

32 Registrar's Signature

DOSALL)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES 001

3001 South HANOVER St, Baltimore, MD, 21225

29d. Date signed (Month, Day, Year)

APRIL, 03, 2007

07-02647

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jean Robinson		- For State	tate of Mary		oartmen <i>ertificate</i>			I Menta	al Hyg		eg. No.	200	7 11129
Physicia	_	Registrar 1. Decedent's Name (First, Mid-	die,Last)							Date of Deat	h		3. Time of Death
andical Examir		Jean	Α.	Rol	oinson					Month April 7, 20		Year	1113 hrs
		4a. Facility Name (if not institut Northwest Hospital	ion, give street and	number)			City, Town, or L Randallstowr		Death			ounty of Deat	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthda	_	f Under 1 Year			B. Date of Bir	th(MM/DE	D/YYYY) 9 Bi Forei	rthplace (State or
Director		213-38-6074	1 M 2 X F	67		Yrs.	Months Days	Hours	Min.	Aug. 1	0, 19		ountry) Maryland
>>		Usual Residence of Decedent 10a. State 10b. County		10c C	ity, Town or	Location							10d. Inside City Limits
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or 28	Director		nwood Roa	4			. 2	21208				U.S.A	
death with the Maryland or items 23a or 28a-f show any must be notified at once.		11. Marital Status	12. Was D	ecedent Ever in	U.S. 1:		ecedent of Hisp	anic Origin			- 14	Race - Ame	rican Indian, Black,
death r	Funeral	1 Never Married 2 X	Married Armed	Forces?	,	If Yes,	specify Cuban,	Mexican, F	Puerto Rio	can, etc.)		White, etc.	
after al", o	by F		ivorced If Yes, Give Y	′еаг			s 2 X No						ite
hours	9	15. Decedent's Education (Sp Elementary/Secondary (0-12		rade completed (1-4 or 5+)			Jsual Occupation of working life.				16b. Kin	d of Business	Industry
36 hin 72 than "dical	blet	12	() College	(1 -4 01 5+)		Cro	ssing G	word			Ra1	ltimore	Co. Schools
id with	Completed	17. Father's Name (First, Middl	e, Last)	CIO	1	8.Mother's	Name (F	irst, Middle, I			. Co. Schools		
Ross Emory Beimschla Dorothy								ıy	М.	Grimn	1		
21 hould nd Me is ma	The property of the state of th										1		
Donald E. Robinson Husband 716 Greenwood Road Pikesville, MD 20a Method of Disposition 20b Place of Disposition (Name of cemetery). Date 20c Location -													
Ore, es la of He If ite	202 Neurod of Bisposition 3 Removal from State crematory or other place)												
tim trent rent:		4 Donation 5 Other		L	ake Vi		em. Par			L/07			, Maryland
Bal permi Depar Impo		21. Signature of Funeral Service	m La	uki.			E FUNER		1102			stown F	21136
Physician	\dashv	23a. Part I. Enter the disease,	or complications tha	t caused the de	ath. Do not e	enter the r	mode of dying, s	such as car	rdiac or re	espiratory arr	est, shock	k, or heart	Approximate Interval Between Onset and
/Medical	5 0	failure. List only one caus Immediate Cause (Final disease	I I was a stance	sive Athero	sclerotic (Cardiov	ascular Dise	ease					Death
Examiner		or condition resulting in death)		s a consequenc									
	إ	Sequentially list conditions, fany, leading to immediate Due to (or as a consequence of):											
	ië.	cause. Enter Underlying Caus	cause. Enter underlying Cause (Disease or injury that initiated										
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cecute			dAMENDE										
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Box 687 c death certifice the attending p	sic			egnant at time o known	f death 5	Other	(Specify)				Ī		
—	Phy	Part II. Other significant con-	9 01		ot resulting i	n the und	erlying cause g	jiven in Par	t I.	23e. Did t	obacco us	se contribute t	o the cause of death?
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Records, The law requir ficate has been s	ם	i		-						perfo	ormed? 2 No	death?	
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Sion of Vital Attending Physician: rdeath. ector: After this certif by the funeral director,	F	27. Manner of Death	28a. D	ate of Injury onth, Day,Year)	28b. Ti	me of Inju	, l	ry at Work?		8d. Describe	how injur	y occurred	
	Certification:		ending vestigation						No				D. J. N Cit.
ivis or At after d Direc lin by	tific	3 Suicide 6 C	ould not be 28e. F	Place of Injury -	At home, farr	m, street,	factory, office b	ouilding, etc	2	8f. Location or Town,		d Number of I	Rural Route Number, City
Dispital	Cer	4 Homicide	etermined (Spec						00 and d	uo to the car	so(s) and	I manner as st	ated
He 24 Fu	ical	(Check only one) 2 Medical E	Physician: To the examiner:On the ba	best of my know sis of examinati	viedge, deati on and/or inv	n occurre vestigation	a at the time, da n, in my opinion	ate and pia i, death occ	curred at	the time, date	and place	e, and due to	the cause(s)
To the within To the comple	Medical	29b. Signature and title of cer	and mann	er stated.			29c. Licens						Month, Day, Year)
	_	(00 M C	20 \$41	700	OLA		O.C.I	M.E.			April	8, 2007	
1		30. Name and address of pers	son who completed	cause of death	Item 23a)								
V			Assistant Medic	al Examine	r 111 F	enn St	reet, Baltim	ore, MD	21201				
S	tate	31. Date filed (Month, Day, Ye	ar) 32	Registrar's Sig	nature	Local							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	****		State Registrar 1. Decedent's Name (First, Middle,	last)		Ce	unicate of L	Jean	2. Date of Dea	th		3. Time of Death	
н	Physicia				- Duff				April	2, 200	Year	5:00 A M	
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	Director		214-24-7555	1 □ M 2 🔀 F	7:	8 Yrs.	Months Days	110070	11/15/	1928		MD	
	pg 🛾		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				-	10d. Inside City Limits	
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	ms 2	Funeral	11. Marital Status	12. Was D	ecedent Ever in U Forces?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin?	(Specify Yes or No-		e - Americk, White,	can Indian,	
9	or its	F	1 Never Married 2 Marri		s 2 XNo	1	1 ☐ Yes 2 No	Specify:	20110 1110211, 010.,	Specif		ite	
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Maryland 21215-0036	o g a p	To Be	Leo William	Hughes				Berna	dette Ca	theri	ne F	reeberge	r
ary	should had a man		19a. Informant's Name/Relationsh						r Rural Route Numbe				
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Baltimore,	permit. Pages Department of I Important: If Its any Injury or of		21. Signature of Emeral Service I	icensee					G.J.Gonce			Home, PA 21122	L .
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	death e atte	icla	in the past 12 months? 1 Yes 2 No	4□Pi	regnant at time of one		Other (specify)			M	onth	Day Year	
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prd	w requir been si should	ted	Teggertur	im	/ 4				- 1				
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Div	after after Dire	Certification:	4 Homicide	Ь	uilding, etc. (Speci	TY)			Chy or rol	wn, State)			
	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funaral Diractor: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifyin (Check only 2 Medical	g Physicien: To	the best of my kn	owledge, dea	th occurred at the time	me, date and p	place, and due to the occurred at the time,	cause(s) and m	anner as , and due	stated. to the cause(s)	
	the Hin 24 the Fi	ledical	one)	and r	manner stated.								
	Som Som	Σ	29b. Signature and title of certifie		4 6		29c. Licens	number		April	7 . 7	-007	
,			Maril	men /	W		_0-4	اے دیا	-		310	0.70	
6)		30. Name and address of person		cause of death (Ite	m 23a) (Type	9, Print) 325	HOSP	PITAL DRI	UE JU	17 €	108	
	/ 	ate	31. Date filed (Month, Day, Year)		2 Registrar's Sign	ature	y LET	y Isher	ore Ind	1001			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2<u>007</u> Month **Physician** 3, Elizabeth Zane 8:00 Sherman April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 13 P Director 155-30-0546 67 Sept 30, 1939 NJ Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Baltimore Reisterstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 Churchberry Court U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race · American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2√☐ No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 5<u>+</u> English Dept Chairman Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William ဂ္ Zane Ethe1 Stiles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 I Richard J. Sherman Husband 6 Churchberry Court Reisterstown, MD 21136 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or otl 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Cremation Ser 4/7/07 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, MD 22. Name and Address of Facility 21. Signature of Funeral Service License 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lice. Immediate Cause (Final disease or condition a. Left few Fracture Approximate Interval Between Onset and Death Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown page 2 should I Completed рееп 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ★ No 24a Was an certificate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) aminer? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospico 1 Yes 2 No 1 Inpatient funeral dire 2 ER/Outpatient 3 DOA Certification: To After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural Fall To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu March 19,2007 Unknown 1 Tes death. 2 Accident 3 ☐ Suicide

P.O. Box 68760. pe Division or Vital Records,

72 hours after

3altimore, Maryland 21215-0036

State Registrar

Medical

and manner stated.

6 ☐ Could not be determined

APR 09

4 Homicide

(Check only one)

29a. Certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number City or Town, State) Church 2007

Reistenstow, MD

29b. Signature and this of certifier

completed cause of death (Item 23a) (Type Print) 30. Name and address of person Trimble H:11 CT. Lutherville, Md 21097 31. Date filed (Month, Day, Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Home

07-02437 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Kimberly M. Snell 1- For State Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day March 29, 2007 1047 hrs Medical Examiner Kimberly Marie Snell 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Saint Agnes Hospital If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Months Director 216-92-4991 06/07/1963 Country) Maryland 1 M 2 XF 43 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location or items 23a or 28a-f show must be notified at once. N/A 1 X Yes 2 No MD Baltimore Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygers.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3138 Wilkens Avenue 21223 United States Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No 1 Yes Specify: White If Yes, Give Year Widowed 4 Divorced 1 Yes 2 No specify: ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Unemployed None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Judy A. Snell (Rowe) Be Edgar H. Snell, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3138 Wilkens Avenue, Baltimore, Maryland 21223 Judith A. Snell (Sister) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 04/09/2007 Baltimore, Maryland Bavview Crematory Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 avoyou Marle T. p 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line linedical Death Complications of end-state renal disease and cocaine use Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any leading to inmediate Dire to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical X UNPENDED certificate has been signed by the attending physician ector, page 2 should be detached for use as the burial -##59;PII,27,perME, g866, 4/25/07 TI The law requires that the death certificate be Box 68760, 23d Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? P.O. ş 1 Yes 2 No 3 Probably 4 Unknown Cirrhosis of liver Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? 1 🗸 Yes ✓ Yes 2 To the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other₄ examiner? Hospital: 1 V Inpatient 2 Nursing Home 5 Residence 6 Other: ER/Outpatient 3 DOA this 1 🗸 Yes ၉ 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification 1 X Natural 1 Yes 2 No Division Pending death. 24 hours after death Funeral Director: the 2 Accident Investigation þ 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be Suicide or Town, State) (Specify) 29a. Certifier 1 within 24 ho

To the Func

completely f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number March 30, 2007 O.C.M.E. MID 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Lina Li, MD 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Mar		e <i>rtificate</i>				giene Reg. No. 200	7 11133
Ą.	Physicia		1. Decedent's Name (First, Middle, Last Audrey Jea						2. Date of Dea Month April	Day Yea	3. Time of Death 10:29A M
	/Medic Examin	_	4a. Facility Name (If not institution, give			4b. City,	Town, or Loc	cation of Death	npixx.	4c. County of D	
- 4-	Funeral		Auxiliary Hou	7. Age (In yrs. last birthda			Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da July 29	Montgor	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	□M 2 X IF 86	Yrs.				July 29	9, 1920 Ok	lahoma
	how how		10a. State 10b. County	1	0c. City, Town or						10d. Inside City Limits
	he Ma 18a-f s otified	Director	Maryland Montgome	ry	Pot	omac 10f. Zip	Code			10g. Citizen of What	1 ☐ Yes 2 No
:	a or 2	Ë	10e. Street and Number 8800 Copenhaver D	rive		101. Zip	2085	54		United St	•
	death	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S. 10	B. Was Deced		anic Ongin? (Spo Mexican, Puerto			merican Indian,
-0020	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fire Z1 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ፟፟፟፝ Widowed 4 ☐ Divorced	Armed Forces? 1		1 ☐ Yes 2		Specify:	ritodri, oto.,		White
5	72 hor	eted	15. Decedent's Edi (Specify only highest grad	ucation de co <i>mpleted)</i>	16a. Dec (Gi	cedent's Usua ve kind of wor	l Occupation k done duri	n ing most of work	ing	16b. Kind of Busine	ess/Industry
7	within iene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4		cher	e retirea)			Public S	chools
and	al Hyg al Other	Be C	17. Father's Name (First, Middle, Last)		1					Maiden Surname)	
yla	nould by Ment narked	입	Walter Herman Dr 19a. Informant's Name/Relationship (7		10h Ma	ilina Addraga		Nell Red	*	er, City or Town, Stat	to Zin Codo)
	nd 2 sh Ith and 27 is n traun		W. Stephen Smith							c, Marylan	
e,	of Hea of Hea item		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐	Domoval from State	20b. Place of Dis				Date	20c. Location - City	
baltimor	Eant: Hant:		4 □ Donation 5 □ Other (Specify)	Metropol			ry 200	7		a, Virginia
ם	Departing Departing Important In any In conce.		21. Signature of Funeral Service Licens	alst MOI	1303 B	00 West	Montgo	mery Aver	me, Rock		Inc. and 20850-2805
		0	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the one cause on each line.	e death. Do not	enter the mod	e of dying, s	such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
F	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	an Cancer	<u> </u>					Years
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury	Due to (or as a	consequence of):						
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08/00,	fficate be executed j physician and is the burial-transit	edical		d							
POX P	certific nding p use as	/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf						23d. Date of	delivery
ŭ.	w requires that the death certi been signed by the attending should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☒ No	1□Live birth 2 4□Pregnant at til 9□Unknown		3 □Ectopic pr 5 □ Other (sp				Month	Day Year
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ပ္	2 88	Completed							24a. Was	psy prior	e autopsy findings available to completion of cause of
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		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient	2 ER/Outpa	tient 3 DC	LOther	6. Place of Deat 4 ☐ Nursing Ho		dence 6 🖾 Other (Assisted Specify)Living
n or	Jing Phys 1. After this funeral di	on: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injur	у	28c. Injury at Work?		28d. Describe	how injury occurred	
INISION	i or Attending Ph fter death. I Director: Affer th c in by the funeral	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		y - At home, farm,	street, factor		s 2□No	28f. Location (Street and Number o	or Rural Route Number,
5	pital or ours fite eral Dir fillec in			ysician: To the best of		eath occurred	at the time.	date and place			er as stated.
	To the Hospital of within 24 hours of To the Funeral D completely filled in	Medical		niner: On the basis of e and manner state	examination and/o						
	To the COUNTY	ğ	29b. Signature and title of certifier	0.4			c. License n	_		29d. Date signed (N	
}	15		30. Name and address of person who	200-ll	ath (Itam 22a) /Tur		D31319	ל י		April 5,	. 2007
	12	1 1	Loreto S. Albiol,				enue,	#305, B	ethesda	, Marylan	d 20814-3128
	Sta	ate	31. Date filed (Month, Day, Year)	32. Régistrar	's Signature	Brank	S				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1, 2007 9:45 PM Mary Patricia Snyder April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Marley Neck Health & Rehab Ctr Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/02/1922 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 ☐ M 2 📉 F 84 MD Director 216-12-3858 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 300 Cloverhill Road 21122 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 X No Specify: Specify: δ White 3 X Widowed 4 ☐ Divorced Year or Dates: Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'amy injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) Custodian School District 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter F. Myers Helen Gilford ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph W. Snyder / Son 300 Cloverhill Road, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Pk 04/04/07 Glen Burnie, MD 22. Name and Address of Facility G.J.Gonce Funeral Home, 21. Signature of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ltona **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) been signed by the s should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has be irector, page 2 s autopsy performe 2 No Hospital or Attending Physician: Be funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28b. Time of 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 2 Accident 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; completely filled in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 600 Kidac

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State Registrar 31. Date filed (Month, Day,

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32 Registrar's Signature

DHMH 17 Rev 1/2001

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Registrar

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6SH 5601 LOCH RAVEN BLVD, BALTIMORE, MD, 21239-2995

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ELENA SABAEVA
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #20b, perFH, G866, 4/13/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:55 Joseph C. Tharpe 2007 /Medical 4a. Facility Name (If not institution, give street and number) . City, Town, or Location of Death 4c. County of Death Examiner Bitimore Healthcare If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min. Months Days Hours 1⊠M 2□F Director 236-28-5445 82 1924 West Virginia 1. Nov. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified anone. 1 ☐Yes 2 X No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 409 H Wheaton Place 21228 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1點 Yes 2□ No If Yes, Give Year or Dates: 1943-46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Supervisor BG&E 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry R. Tharpe Lillian E. Whetzel 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Derus - Daughter 9615 Haven Farm Road Unit G; Perry Hall, MD 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4/10/2007 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 4 20 2007 Baltimore, Maryland 22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke Funeral Home of Catonsville, Inc. 21. Signature of Fee eral Service Licenses 1630 Edmondson Avenue; Catonsville MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** -OROHARY Oyes() disease or condition resulting in death) /Medical Due to (or as a consuluence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-trans Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical the attending p use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy certificate Vital 1☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 2 VZR/Outpatient 3 □ DOA 2 1 Inpatient within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death
Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Attending 5 ☐ Pending investigation Injury Division 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ò 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. nd title of certifie 29d. Date signed (Month, Day, Year) D00546 no completed cause of death (Item 23a) (Type, Print) Name and address of perso AMBHER MO 31. Date filed (Month, Day, State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear **Physician** 5:04 P M April 2007 Philomena Veltre /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Berlin If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Worcester 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🕱 F Months Yrs. Director 91 1915 Pennsylvania Oct. 8, 191-10-7424 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location. 10a. State 28e-f ehow other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Worcester Berlin 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or Items 23a 40 Driftwood Lane 21811 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 end 2 should be filed within 72 hours after onent of Heelth and Mental Hygiene. ant: If Item 27 Ie marked other than "natural", or Ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 31X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Audio Visual Elementary/Secondary (0-12) College (1-4or 5+) Book Keeper 12 Equipment Rental 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 180/0 Pasquale Caruso Angela Rizzo ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Heelth a Important: If Item 27 Is eny injury or other trei ance. Lorin Veltre 40 Driftwood Lane; Berlin, MD 21811 Son 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State DO 13: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Rother (Specify) Entombment Loudon Park Mausoleum 4-6-2007 Baltimore, Maryland 22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke Funeral Home of CatonsvIlle, Inc. 1630 Edmondson Avenue; Catonsville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) wolecuptitus **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Vital Records, 7424 1 Yes 2 HNo 3 Probably 4 Unknown Be Completed this certificate has been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 11No 1 Yes Physician: 25. Was case referred to medical 26. Place of Death Check only one examiner? Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 / impatient Certification: To 1 ☐ Yes 2 ☐ №6 2 FR/Outpatient 3 FDOA ivision of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter de To the Funeral Direct completely filled in by t filled in by 4 \ Homicide Hospital 1 1. Len't ying Physician: To the best of my knowledge, death underest it he lime, date and place, and due to the dauta(s) and manner as stated. 2 Medical Examinat: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) o the 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) D5361 2/07

State Registrar 30. Name an

31. Date fifed (Month, Day, Year)

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Philomena

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Heath was Dr Berli

Terson who completed cause of death (Item 23a) (Type, Print)

9733

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 5:00P M JAMES JULIAN WILKINS 2007 APRIL 02 */Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A 1201 ROSSITER AVENUE BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth 01/13/1948 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours **M** 2□ F MARYLAND 59 Yrs. 212-50-2428 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1X Yes 2 No N/A BALTIMORE CITY MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21239 1201 ROSSITER AVENUE Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 🏖 ☐ No Specify: Specify: BLACK à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MD STATE DEPT. OF Elementary/Secondary (0-12) College (1-4or 5+) YEARS 12TH 3 SOCIAL SERVICES CASE MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARIE WILKINS JULIAN COATES ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1201 ROSSITER AVENUE, BALTIMORE, MD 21239 ROSALIND WILKINS / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/06/07 CATONSVILLE, MD METRO CREMATORY 22. Name and Address of Facility ef Funeral Service License HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Approximate Interval Between Onset and Death 23a. Post Enter the disease, or complications that caused the dispose, in hear failure. List only one cause of a chiline. Do not enter the mode of dving, such as cardiac or respiratory arrest. Imme at Cause (Final diseas r condition resulting in death) **Physician** /Medical Due to (or asca consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (cissuse or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2□ No 24a. Was an 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred

death certificate be executed Box 68760. P.O. ivision or Vital Records.

show

permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at

and

burial-1

as

nse

signed by t

page 2 should

Certification:

Medical

1/1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

has

physician s the buria

Saltimore, Maryland 21215-0036



spital or Attending P nours after death. neral Director: After i y filled in by the funera

State Registrar

and manner stated.

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, $\overline{\text{Print}}$) With Raven BWd, Balt, MO21235

5601 59

31. Date filed (Month, Day, Year) APR 0 9 2007 Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2007 **Physician** A M 1, Joseph C. P. Wang April 9:12 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) October 22, 1928 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1X M 2□ F 7. Age (In yrs. last birthday) **Funeral** Hours Days 204-26-6472 78 China Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Directo Maryland Montgomery Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9900 Potomac Manors Drive 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify Specify: Asian 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5-1-Elementary/Secondary (0-12) Professor University 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hwa-Lung Wang Shu-Syiang Hsia မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Betty C. Wang / Wife 9900 Potomac Manors Drive, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven cemetery 20c Location - City or Town, State Silver Spring, 20a. Method of Disposition April 4, 1 Burial 2 □ Cremation 3 □ Removal from State 2007 Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funge | Service Licensee 22. Name and Address of Facility.
Robert A. Pumphrey Funeral Home/Rockville, Inc. Magalette Bayun M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiac Arrhythmia Minutes /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Years Sequentially list conditions, Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-transit Congestive Heart Failure Years Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cerebrovascular Accident 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 12 No ate has b certificate 1∐ Yes or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2N No ၉ this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital

April 1, 2007 pleted cause of death (Item 23a) (Type, Print) Shady GROVE
32. Registrar's Signature VICOL 0 31. Date filed (Month, Day, APR 0 9 2007

and manner stated.

State Registrar 29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29date of Maryland Department Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Warther **Physician** 11:17 AM 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore staale LOU If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex last birthday) **Funeral** 79 Yrs. 219-20-9102 1 M 2 NF PENNSYLVANIA 7-4-1927 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 X No ROSEDALE BALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21237 U.S.A. 8021 EDGEWATER AVENUE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify: 2 WHITE Lather, Doroth altimore, Maryland 21215-003 3 ☑ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BAKER, SR. AGNES ROY E. MARY (MALEE) ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trat once. ERIC WARTHEN/SON 8017 EDGEWATER AVE ROSEDALE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HOLLY HILL CEM. 4-6-2007 MIDDLE RIVER, 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Ligensee 1211 CHESACO AVE ROSEDALE, 21237 Approximate
Interval Between
Onset and Death
A Nours 23a. Part1. Enter the dishate, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** DOXIA /Medical Due to ras a consequence of): **Examiner** hydration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 pronths?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death P.0. 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 □Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has b page 2 s autopsy performed/ Yes 2 No certificate 1□ Yes 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō within 24 hours a

To the Funeral Completely filled Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier DSS 306 V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 9 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** ERNESTINE WYSOCKI L. 2007 7:35 p April 05. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Catonsville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | March | 31,1909 Charlestown Care Center Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 214-40-8518 1 □ M 2 ■ F 98 Illinois Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland N/A Brooklyn 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 301 Pontiac Avenue 21225 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Balto. City Schools Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Κ. Wysocki ၉ Lydia Huebner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis J. Weinkam Jr. (attorney) 1002 Frederick Road, Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State Loudon Park Cem. 04-10-07 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signalure of Finer Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Avenue, Baltimore, Kevin E. Ecker 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Cisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2☐No 3☐ Probably 4 □Unknown Completed 24h Ware autopsy findir 2 Be ဥ Certification:

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

and burial-trar attending physician for use as the buria sate has t een signed by the page 2 should be detached cerlificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

Funeral

Director

Hygiene. sther than "natural" or items 23a or 28a-f show ent. the Medical Examiner must be notified at

with the Maryland

death

filed within 72 hours after

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other i any Injury or other traumatic event, <u>tr</u>

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

					autopsy performed?	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
	Was case referred to medical			26. Place of Deat	h (Check only one)	
	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐]ER/Outpatient 3□[DOA Other: 4- Nursing Ho	me 5 Residence 6	□Other (Specify)
	Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred
	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ome, farm, street, factory)	ory, office	28f. Location (Street and City or Town, State)	l Number or Rural Route Number,
98	a. Certifier 1 Certifying	Physician: To the best of my kno	owledge, death occurre	ed at the time, date and place,	and due to the cause(s)	and manner as stated.

29b. Signature and title of certifie

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

nd address of person who completed cause of death (Item 23a) (Type, Print) IM va 14

Orone Can Calouwla

State Registrar

Medical

31. Date filed (Month, Day, Year)

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Day Year Month **Physician** Ε. YEWELL 30, 20:45 % Mar. 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Univ. of Maryland Medical Syst. Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. 18. Date of Birth (Month, Day, Year)

Dec. 8, 1929 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 1 F 214-24-9508 Maryland Director Usual Residence of Decedent the Maryland 10d. In side City Limits 10c. City, Town or Location 10a. State 10b County permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "naturel", or iteme 23a or 28a-f ehow enty Injury or other traumatic event, the Madical Examinational be notified at once. 1 Yes 2 □ No N/A Maryland Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21230 613 East Fort Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes. Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland 12 Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Estelle Caskey Benjamin Harvey ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 613 East Fort Avenue, Baltimore, Maryland John W. Yewell Jr. (Husband) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery Date 20c. Location - City or Town, State 104-04-07 Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 East Fort Avenue,Baltimore, Maryland 21230 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23d. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** a. Cardiac Pulmonary Arrest
Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Congestive Heart Failure that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Diabetes Mellitus Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal deal
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) o 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Maknown PAOD, s/p CABG 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2 NX 1 Yes Division of Vital 25. Was case referred to medical examiner?
1 ☐ ¥es 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Kpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

31. Date filed (Month, Day, Year) State Registrar 0

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. William R. Flinn

miles

DHMH 17 Rev 1/2001

D44188

22 S. Greene Street, Baltimore, Md 21201

April 5,2007

		•	1 - For State Registrar				Cer	tificate	e of L	Death	1		Reg.	No.		
			Decedent's Name (First, Middle)	fle, Last)								2. Date		Day	Year	3. Time of Death
	Physicia			Ste	phen	Ash						Apr			2007	2206 P ^M
	/Medic Examin		4a. Facility Name (If not institution					4b. City,	Town, or	Location	of Death			4c. Count	y of Death	
			Union Hospita	al					kton						cil	
	Funeral		5. Social Security Number	6. Sex	7 -	ge (In yrs. last b		If Under Months	1 Year Days	If Unde Hours	Min.	8. Date (Mont	of Birth h. Day, Y	ear)	9. Birth	olace (State or Foreign ntry)
	Director		213-20-4988	1 XM 2	8	31	Yrs.					FEB	18, 1	926	Mai	ryland
	pug *		Usual Residence of Decedent 10a. State 10b. Count	v		10c. City, To	wn or Lo	cation								10d. Inside City Limits
	fanyla sho	ō		cil		Ell	ton									1 XYes 2 ☐ No
	the A	Director	10e. Street and Number					10f. Zip	Code				10g	. Citizen of	What Cou	ntry?
	with 3e or	<u> </u>	104 Stockton	Street				2	1921					Unit	ed St	ates
	ns 2	era	11. Marital Status	12. Was	Deceden	t Ever in U.S.	13.	Was Dece	dent of H	ispanic O	rigin? (Sp	ecify Yes Rican, et	or No-		ice - Ameri ack, White,	
ယ	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or Items 23e or 28a-f show uther then "naturel", or Items 12e Lodfiled at ant, the Medical Examinat must be Lodfiled at	by Funeral	1 Never Married 2 Ma	rried 1 X	Yes 2 es, Give er or Dates:	World	ĺ	1 ☐ Yes		Specify		riioari, ot	<i>-,</i>	Spec		. 0.0.
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5-0	72 hornatu	Completed	15. Decede (Specify only high	ent's Education est grade comp	leted)	16	a. Dece	dent's Usua kind of wo DO NOT u	al Occupa	ation during mo	st of wor	king		b. Kind of I Paper		-
2	ithin ne. hen.*	ldm	Elementary/Secondary (0-12	Col	lege (1-4or	5+)		rklif						Manuf		
2	e filed within al Hygiene. I othar then ' vent, the Me		6 17. Father's Name (First, Middle	a Last)			го	LKTTT	L OP			ne (First, M		iden Suma		IIIg
anc	ntal had and and other	Be		J, 2001)								Dorse				
ž	2 should be and Mental is markad reumatic ev	2	Stephen Ash	nshin /Tvne Prir	nt)	19	b. Mailir	na Address	S (Street					City or Town	n, State, Zi	p Code)
Maryland	d 2 s th an th an treur		Stephen E. A					-						nd 21		
é,	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23e or 28a-1 show or other treumatic event, the Medical Examinet must be notified at		20a. Method of Disposition			20b Place	of Dispo	sition (Na	me of			Date				own, State
Baltimore,	Pages nent of I ant: If it		1 Burial 2 □ Cremation 1 Donation 5 □ Other		I from State		y H	ill	outer plac		Apri 2007	ı),	C.	harry	H-11	. Maryland
Ė	그런 변경 .		21. Signature of Funeral Service			Metho	25	Name at	nd Addre	ss of Fac	ility	-				
Ba	parmi Depa Impo any i		1 Donald	2 N	dis	\mathcal{C}	1	icks 03 W.	Home	ckto	n St	erais reet,	Elk	A. ton,	Mary1	and 21921
			23a. Part1. Enter the disease, shock, or heart failure. L	or complications	that cause	ed the death. D	o not en	ter the mod	de of dyin	ig, such a	s cardiac	or respira	tory arres	t,		Approximate Interval Between
	Proysician		Immediate Cause (Final	st only one caus	n on each	yocar									74.	Onset and Death
	/Medical		disease or condition resulting in death)	a	ue to (or a	s a consequenc	e of):	4 11	Tu	cen	0 /)					4
ı	Examiner			h .	(orona	vry	Ar	Fery	di	sea	عو				ankour
Ł		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	e of)	11	1		0		disa		unknows				
3	cuted nd ransi	Examine	Cause (Disease or Injury that initiated events	U	15/2	uch	ve	rux	ary	orsa	ase	anznou				
ó	be executed sician and burial-transit		resulting in death) Last		oue to (or a	is a consequenc	e of):								- 17	
68760,	ate b hysic the b	Medical		d												
	The taw requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Mec	IF FEMALE:	220 15 11	as outcom	ne of pregnancy								334 [Date of deli	Very
Box	eath cer attendin for use	ian	23b. Was decedent pregnant in the past 12 months?	10	Live birth	e of pregnancy 2 ☐ Fetal dea at time of death	th 3[□Ectopic p □ Other (s		/					Month	Day Year
0	the a	Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Unknown		3(_ Other (s)	p o city)							
<u>α</u>	res that the de igned by the a be detached i		Part II. Other significant cond	itions contributir	ng to death	but not resulting	j in the t	underlying	cause giv	en in Par	t I.	23e	. Did toba	cco use co	ntribute to	the cause of death?
ds,	signe signe d be	db	Luna	lax								Щ	1 Yes	2 □ No	3 🗌 Pro	obably 4 Unknown
Ö	w require been si should b	ete										24a	. Was an	24	o. Were au	topsy findings available
3ec	has has	Completed by											autopsy perform	ed?	death?	completion of cause of
a			OF Man once referred to made	201						as Dia	co of Des	ath Check	201	No	1 🗌 Yes	2 No
Division of Vital Records,		o Be	25. Was case referred to med examiner? 1 Yes 2 No	Hospita	t: 1 Minpa	itient 2 ER/	Outpatie	nt 3□ D	OA Ott				177	ice 6 🗆 C	other (Spec	cify)
of	F = F	To I	27. Manner of Death	28a	. Date of Ir	njury 28t	. Time o		28c. Inju	y at				v injury occ		
on	iding I Ih. Aftar funer	tlor	1 ☑Natural 5 ☐ Pen 2 ☐ Accident inve	ding stigation	(Month, L	Day Year)	Injury	М	Wo 1 □	Yes 2	□No					
/isi	or Attencafter death Director: In by the	fica	3 ☐ Suicide 6 ☐ Cou	ld not be	. Place of	Injury - At home	farm, st	reet, facto	ry, office			28f. Loca	ation (Stre	et and Nui	mber or Ru	iral Route Number,
Di	after Direction din t	Certification;	4 Homicide		bullaing,	etc. (Specify)							0, , 0,,,,	01410)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certif	ying Physician:	To the be	st of my knowled	ige, dea	th occurred	d at the ti	me, date	and place	e, and due	to the cau	use(s) and	manner as	stated.
	e Ho 124 h	edical	(Check only 2 Medic one)	al Examiner: O	n the basis id manner	of examination stated.	and/or II	nvestigatio	n, in my c	opinion, d	eath occ	TILEO AT THE				
	To th To th Comp	ž	29b. Signature and title of cert	ifier				29	c. Licens	se numbe	r	_				h, Day, Year)
		H		Vere	hcl	ev S	M	(1)	00	023	332			<u> </u>	14/	<i>0 1</i>
	j		30. Name and address of pers	on who complete	ed cause o	of death (Item 23	a) (Type	, Print)	2	-/-2	Q	F	067	MI	1210	207
_	þ		30. Name and address of pers	HIDEU	INS	115	(VO)	14 01	- 04	16 0	5	' ن	K6	שייינ	147	~
		ate	31. Date filed (Month, Day, Ye	ar)	32. Regi	strar's Signature										
	Regist	rar	APRO	9-2007	1 30 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	10 - 10	1/30	Marks 6)							
D	HMH 17 Rev 1/	2001	* * * * * * * * * * * * * * * * * * *	& LOUI	of the state of th		RIGIN	AI								
						Or	IIGIN.									<u> </u>

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			For State	State of Ma		epartment of Certificate of		and Mental Hy	/ /	manufacture and a second and a	
	P [®] hysici /Medio	al	1. Decedent's Name (First, Middle 4a, Facility Name (If not institution	SABY		scio	n, or Location	2. Date of De Month MARCH	ath Day Year 21 2007 4c. County of Dea	3. Time of Death	
	Examin Funeral Director		BALTIMURE 5. Social Security Number 219-05-6729	VA Medica	e (In yrs. last birthe	day) If Under 1 Ye	ar II Under	CRC F24 Hrs. 8. Date of Bir (Month, Da June 1	th y, Year) 9. Bir	thplace (State or Foreign ountry) Jaryland	
	1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygenes remains a first stranged other then 'naturel,' or liems 23a or 28a-f show ther treumatic event, the Madical Examinar must be notified at	Director	Usual Residence of Decedent 10a. State 10b. County MD Anne	Arundel	10c. City, Town o	or Location colis				10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
		al Dire	801 Rolling View Drive			10f. Zip Cod	10f. Zip Code 21409			10g. Citizen of What Country? USA	
920		by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? ied 1∑Yes 2☐I IfYes, Give Year or Dates:		13. Was Decedent of If Yes, specify C		rigin? (Specify Yes or No in, Puerto Rican, etc.)			
Maryland 21215-0036		Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)		16a. D	Decedent's Usual Oc Give kind of work do ife. DO NOT use rei City Lat	ne during mos tired)	st of working	16b. Kind of Business Highway	Undustry Department	
		To Be C	17. Father's Name (First, Middle, Samuel Alascie	•				er's Name (First, Middle ary Barranco			
			19a. Informant's Name/Relations Mary B. Peterso		1			per or Rural Route Numb Drive Anna			
Baltimore,	of of the state of		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		cemetery,	Disposition (Name of crematory or other and Veterar	place)	March 26,	20c. Location - City or Crownsvi		
Balti	permit. Pag Department Importent: any Injury c		21. Signature of Funeral Service	Licensee (\$5	22. Name and Ad Barranco 495 Gov.	dress of Facil O & Son Ritch	ns, P.A. Se	everna Park everna Park	Funeral Home	
	Physician /Medical Examiner		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	Due to (or as	ne.	t enter the mode of	dying, such as			Approximate Interval Between Onset and Death	
68760,	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	cal Examiner									
. Box		Physician/Med				3 ☐ Ectopic pregna 5 ☐ Other (specify	□Ectopic pregnancy □ Other (specify)			23d. Date of delivery Month Day Year	
ds, P.		by	Part II. Other significant conditions contributing to death but not resulting in the un				grand			tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown	
		Completed						24a. Was auto perfe 1 \(\text{Yes}	an 24b. Were a prior to death?		
Division of Vital		Certification: To Be	25. Was case referred to medical examiner? 1 Types 2 No Specific Check only one) 1 Specific Check only one)								
3DIVI									Bural Route Number,		
PerD		Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)								
ठ	vith Con		29b. Signature and title of certifie		M.D			70			
	5+1		30. Name and address erson Ayang 31. Date filed (Month Day Your	who completed cause of a	death (Item 23a) (T	NO-Ree	NeSt	Reet BALL	inore, MD	21201	
: "	Sta Regist	ate .	31. Date filed (Month, Day, Year) MAR 2 3 2007 32. Refistrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 01:25 2007 Willard Earl Blackburn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil 71 West Shady Beach Road North East If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JAN 3, 194 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1∭M 2□F Days Hours Yrs. Maryland **Director** 213-38-9911 66 1941 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28e-f show r then "natural", or items 23e or 28e-f shovine Medical Examinar multibe nutified at 1 ☐ Yes 2 No Funeral Director North East Maryland Ceci1 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 71 West Shady Beach Road 21901 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Long-distance I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Trucking Owner/Operator/Salesman treumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) s 1 and 2 should be fill f Health and Mental H tam 27 Is marked oth Be Sylvia Watson Willard Blackburn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ant: If itam 27 Is ury or othar tree Brenda A. Blackburn/Wife 71 W. Shady Beach Road, North East, Maryland 21901 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 5, 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Sharps Cemetery Fair Hill, Maryland P.A. Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee 23a. Patt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 105/4/2 Cuncky disease or condition resulting in death) VEUVS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dualto (or as a consequence or): Examiner The law requires that the death certificate be executed nding physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death signed by the a 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2/X/No 3 ☐ Probably 4 ☐ Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 22 No 1 Yes Be

certificate Division of Vital To the Hospital or Attanding Physician: 70 this After thi funeral of Certification: death. within 24 hours after death
To tha Funerel Diractor:
completely filled in by the

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home X Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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ar 31. Date filed (Month, Day, Year)

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30. Name and

ddress of person who completed cause of death (Item 23a) (Type, Print)

				State o	f Marylan	d / Depa	artmen	t of H	ealth a	and M	ental Hv	giene.	9.5.0	
		1	For State Registrar	0.0.0	. marytan		rtificate				_	Reg. No.	007	1146
	: 1-1		1. Decedent's Name (First, Middle								2. Date of De.	ath Dav	_ Year	3. Time of Death
	hysici: /Medic		Elizabeth Ann								Mar 23	_	7	12:35 A M
E	xamin	er	4a. Facility Name (If not institution						Location o	f Death			ounty of Dea	
F.,			Clinton Nursin 5. Social Security Number		7. Age (In yrs.			Clin 1 Year	ton If Under :	24 Hrs.	8. Date of Birt	h		thplace (State or Foreign
	neral ector		218-22-3373	1□M 2XF	79	Yrs.	Months	Days	Hours	Min.	(Month, Da 07-14-	y, Year)		yland
P			Usual Residence of Decedent		10- 69	· ·								404 leaide Cital inite
laryla	o po	<u>_</u>	10a. State 10b. County	1 7		ty, Town or Lo	cation							10d. Inside City Limits 1 X Yes 2 □ No
the the	COUNT	ect	Maryland Anne	Arundel	Lo	thian	10f. Zip	Code				10g. Citize	n of What Co	ountry?
death with the Maryland	38 or	Funeral Director	981 Margarita	Street				711				U.S		•
death	L ma	ner	11. Marital Status		edent Ever in U	.S. 13.			spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)			erican Indian,
after .	or its	by Fu	1 Never Married 2 Marri	ied 1 ☐ Yes If Yes, Giv	2 ∑]No ∕e		1 ☐ Yes		Specify:	, , , ,	Thous, Grony	1		hite
Within 72 hours after ene.	al Ex		3 X Widowed 4 ☐ Divorced 15. Decedent	Year or D	ates:	16a. Dece	dent's Usus	al Occupa	ation			16b Kind	of Business	
7 nin 72	n 'n Medic	piet	(Specify only highes	st grade completed)	(Act E)	(Give	kind of wo	rk done d	luring most	t of worki	ng	100. 14810	01 00311033	rindustry
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Aarylan 2 should be f and Mental	narke natic	မှ	William Kyne							He1d				
Mar nd 2 sh lith and	7 is m traum		19a. Informant's Name/Relations								al Route Numb			
s 1 and 2 theelth	Important: If item 27 is marked other then "natural, or itema 23a or 28e-f show eny injury or other traumatic event, the Medical Example must be notified at ones.		James E. Bonne 20a. Method of Disposition	r – Son	20b. F	Place of Dispo	sition (Nar	ne of			Lothian Date			ZU/II Town, State
Baltimore, permit. Peges 1 at Department of Hee	7 or 0		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State	cemetery, cre rt Linco	,		٠ ١ ـ	3-27	7-2007	Bren	twood.	Maryland
alt. I	portal y inju		21. Signature of Funeral Service				2. Name an		-					imore Ave.
n aa.	eny i		1 (alany)	and.	1013	73Ga	sch's	Fun	era1	Home	e, P.A.	Нуа	ttsvi1	le, MD 20781
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that confly one cause on a	aused the deal	th. Do not en	ter the mod	le of dying	g, such as	cardiac o	or respiratory a	rrest,		Approximate fnterval Between Onset and Death
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	dical miner		resulting in dealth	Due to	(or as a consec	quence of):								
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be executed	nysicien and he burial-transit	Ex	resulting in death) Last	Due to	(or as a consec	quence of):								
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Bath ce	atten I for u	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live t	ointh 2 ☐ Feta nant at time of c	al death 3	□Ectopic pr					23	Id. Date of de Month	Day Year
o 🖁	by the achec	hysi	9 ☐ Unknown	9□ Unkn	own									
	s been signed to should be det	by P	Part II. Other significant condition	contributing to d	eath but not res	sulting in the u	ınderlying o	ause give	en in Part I		23e. Did 1	obacco us		to the cause of death?
Hecords he taw requires	sen si	ted	Certifica	7	/	1					10	Yes 2	No 3∏P	robably 4 Hinknown
9 g	has b e 2 st	Completed	- Julin	2 /- c	bros	79_					24a. Was	psy	prior to	utopsy findings available completion of cause of
	certificate has birector, page 2 s										1 Yes	ormed? 2 X No	death? 1 ☐ Ye	s 2□ No
Vital	certif	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	In a silvert OF] FD/O		Othe			(Check only			
₽ Ę	: After this certifica funeral director, p	H-	27. Manner of Death	28a. Date	of Injury	28b. Time of		28c. Injury	/ at		me 5 Resi			ecity)
ISION Attending death.	tor: Aft the fun	atio	1. ☐ Natural 5 ☐ Pendin 2 ☐ Accident investi	gation	nth, Day Year)	Injury	м	Worl	Yes 2	No				
DIVISION or Attending efter death.	Diractor: in by the	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inad 288. Place	e of Injury - At h	nome, farm, st	reet, factor	y, office			28f. Location (City or To	Street and wn, State)	Number or F	Rural Route Number,
Hospital or 24 hours effe	arai D			5						10.0000	Policy Court of the Court of th			
Mospital 24 hours 6	Funeral Dirac etely filled in by	edical	29a. Certifier 1 Certifyir (Check only 2 Medical	Physician: To the Examiner: On the b	e best of my kn basis of examination as stated.	ation and/or in	vestigation	i, in my o	pinion, dea	ith occur	and due to the red at the time,	date and p	olace, and du	e to the cause(s)
To the within 2	To the	Me	29b. Signature and title of certifie				29	c. License						nth, Day, Year)
			1(/)	2/			•	50	45	4		Mea	ch,	73,07
1)		30. Nam, and address of person	pleted cau	se of death (Ite	m 23a) (Type	Print)		7		0 =			23,07
(6)			31. Date filed (Month, Day, Year)	798 0	Registrar's Sign	1-01	Iwa	sh.	71.	~ /	200	0/0	7	
4.3	Sta Registi		MAR 2 7 2007	Bain	A.	(All	-							

Physician /Medical **Examiner** Examine law requires that the death certificate be executed

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attending physician

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certificate has

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After

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neral Director: /

within 24 hours a

Hospital or Attending

Be

Certification: To

Medical

Physician

/Medical

Examiner

Funeral

Director

rai", or Items 23a or 28a-f show Examiner must be notified at

'natural", or

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, i

Director

Funeral

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Completed

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filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

burial-tran the ģ s been signed b should be deta funeral

Division or Vital Records, P.O. Box 68760

Physician/Medical ۶ م Completed

Hospital: Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural

5 ☐ Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

MAR 2 6 2007

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29a. Certifier

(Check only

29c. License number D0060117

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 3/19/07

mD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eriz J. Park, M.D. 9901 Medical Center Dr, Rockville, MD 20850 31. Date filed (Month, Day, Year)

State Registrar

ຶ State Registrar EED

MAR 2 6 2007

31. Date filed (Month, Day, Year)

AVE

BALTIMORE, MD 21239

900 CATON

Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Milton **Physician** 8:15 DM BROWN 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bultimore Westington Medical Center Hrunde Hone BURNIC If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 X M 2 □ F 43 217-86-5062 ,1963 g Marvland Aug. Director John Milton Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 28a-f show Yes 2 No Glen Burnie traumatic event, the Medical Examiner must be notified MD Anne Arundel Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number ö U.S.A. 21061 6444 Washington Square or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Black Specify Specify: þ 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 3 yrs is marked other than Elementary/Secondary (0-12) Health Ins. Co. Data Entry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Naomi Garnett John Brown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trai 6444 Washington Square, Glen Burnie, MD Naomi Brown (Mother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Mt Zion Cemetery 3/24/07 Laurel, MD 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signatur uneral Service Dicens 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final month metastatic adenocavcinoma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner UNKNOWN Numan Immunovirus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed the burial-transit Exami and resulting in death) Last Due to lor as a conse uence of): Box 68760, attending physician Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Vear 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 1 □ Yes 2 □ No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an ate has b autopsy performed2 1∐ Yes this certificate 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1 Tyes 28d. Describe how injury occurred al or Attending Ples after death.
I Director: After the in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital thin 24 hours a 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Function 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 18, 200 00022463 10 30. Name and address of person who con pleted cause of death (Item 23a) (Type, Print)

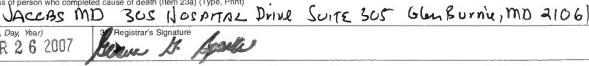
Registrar

State

31. Date filed (Month, Day, Year)

MAR 2 6 200

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Registrar Amend #4a, 10e & 12 per PHYS Francisco of Orgath CNM Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:16 A 23, 2007 Richard Clay Bowers March /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Drive 210 Wyngate Drive 219 Wyngate Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F Yrs. Director 212-03-2250 87 Nov. 5. 1919 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 □ No Director Frederick Frederick Maryland 10g. Citizen of What Country? 10e. Street and Number 21701 United States 219 Wyngate Drive 210 Wyngate Drive Funeral death \ 12. Was Decedent Ever in U.S. Armed Forces? 1XX es 220100 If Yes, Give Year or Dates:1942—1947 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Š 3 ☐ Widowed 4 ☐ Divorced 'natural' Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) Il Hygiene. other than Underwriter Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any liniry or other traumatic event once. Be ဂ္ Elmer E. Bowers Lillie May Hickman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Wyngate Drive, Frederick, MD 21701 Elaine Bowers / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State demetery, cremator State demonstrate 3/26/2007 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 Approximate Interval Between Onset and Death e, or complications that guised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause of each line____ 23a Part 1. Enter the diseas shock, or heart failure. enkemice Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner spital or Attending Physician: The law requires that the death certificate be executed outs after death.

neral Director: After this certificate has been signed by the attending physician and iffiled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 2 X No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🗌 Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral L Hospital 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

istrar's Signature

65 Kande

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31. Date filed (Mon

rederick, MD 2170

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1545 M Olivia Bailey March 23 Reese 2007 /Medical 4b, City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner srow# D 1+1 The Johns Hopkins HOSPITA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🗙 F 20 Director March 3,2007 Maryland Usual Residence of Decedent 10a State 10c. City. Town or Location 10d Inside City Limits 10h County Show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Marvland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21788 United States 6574 Mountaindale Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education within 72 | (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental Ashley Wester Patrick Bailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) s 1 and 2 s f Health an Item 27 is r 6574 Mountaindale Rd, Thurmont MD 21788 Ashley Bailey / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Itel any Injury or otl 1 Burial 2 □ Cremation 3 □ Removal from State Walkersville, Maryland 4 Donation 5 Other (Specify) 3/27/2007 G1ade Cemetery 22. Name and Address of Facility Stauffer Funeral Home, P.A. 21. Signature of Funeral Service Lice rulles 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the disease shock, or heart failure e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 20 days **Physician** Cardiophlmonary tailure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Frematurity, Agenesis of Corpus Callosum, Seizurt, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No After this certificate has been si funeral director, page 2 should I Completed Hypoplasia, Cleft Palate, Ascites, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hydronephrosis, Syndactyly 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fi Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar AJ4147357T5380

600 North Wolfe Street Baltimore, Maryland 21287

March 23, 2007

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laura Lynn Landgraf

7 2007

31. Date filed (Month, Day, Year) MAR 2

State of Maryland / Department of Health and Mental Hygiene [] For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3/18/07 Milton . Lerov 5:00a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Garrett Oakland 50 Doc Bernard Rd. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | (Month, Day Ye 9/8/1934 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7.-Age (In yrs. last birthday) **Funeral** 1<u>M</u>M 2□F Yrs. Director 235-52-2113 72 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10h Counts 10c. City, Town or Location rithen "natural", or items 23a or 28a-f show the Medical Exeminant be notified at 1 ☐ Yes 2 ☑ No Director Parsons Tucker 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 26287 Rt 2 Box 208 deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: δ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auto Repair Mechanic 12 other 7 is marked othe traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Pages 1 and 2 should be Sophia Roth Nellie Ball Rau1 Fay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a :: if item 27 is or other tra 50 Doc Bernard Rd., Oakland, MD 21550 <u>Janet Ball/ Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State njury o Horseshoe Run, WV 3/21/07 4 ☐ Donation 5 ☐ Other (Specify) Texas Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home Deparement 32 S. Second St., Oakland, MD 21550 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive heart years /Medical Due to (or as a consequence of): Examiner Years Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien end s the burial-transit Hospital or Attending Physicisn: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical ettending p IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Renal Failure 1 Yes 2 No 3 Probably 4 Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 ☐ Yes 2/11/0 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2☐ No ၉ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification: s effer deam rai Director: Affr 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours e To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1533 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VA+ 311 N. 4th St., Oakland, MD 21550 Thomas G. Johnson, MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year) MAR 2 3

32. Registrar's Signature

2007

			For State Registrar		State o	f Maryland		artment of F tificate of i			giene Reg. No.	4 U U I	11153
	Physici /Medic		1. Decedent's Name Lane A							2. Date of De 3Mon3n0 /	oth 070ay	y Year	32Time of Death M
7	Examin		4a. Facility Name (// FROSTBUR				R	4b. City, Town, or FROSTBU	r Location of Deat RG	h	4c. County of Death ALLEGANY		
	Funeral Director		5. Social Security N 201–05–64	85	. Sex 1 → M 2 □ F	7. Age (In yrs. Ia 85	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.		th 9 2 2 2	9. Birthi NOTT	olace (State or Foreign NGHAM, PA
	aryland ehow).	Usual Residence of 10a. State	10b. County			, Town or Lo						10d. Inside City Limits
	with the M s or 28a-f be notified	Directo	MD 10e. Street and Nur			FRO	STBURG	10f. Zip Code 21532		11	-	izen of What Cou	ntry?
936	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. Item 27 is marked other then "naturel", or iteme 23s or 28s-f ehow other traumatic evant, the Madical Examinal must be notified at	by Funera	10711 SKI	ied 2🏋 Marrie	12. Was Dece Armed Fo	2 No 942-		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No		14. Race - Ameri Black, White, Specify: WHI	can Indian, etc.
Maryland 21215-0036	d within 72 hor giene. ir then "nature ine Medical E	Completed	(Spec		Education grade completed) College (1	-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired EMAN	durina most of wo	rking		ind of Business/Ir	dustry
and	id be file entat Hyg ked othe Ic evant,	To Be C	17. Father's Name							me (First, Middle,			
	s 1 and 2 should be filed within if Heelth and Mental Hygiene. Item 27 is marked other then other traumatic evant, the Mental country in the Mental countr		19a. Informant's Na MARY CAM		O (Type, Print) WIFE			ng Address (Street SKIDMORE					
Baltimore,	permit. Peges 1 a Depertment of Hee Important: If Item any Injury or othe Once.				B □Removal from poify)	Sinta Ce	emetery, crei	sition (Name of natory or other plac AEL CEME)			20c. Location - City or Town, State FROSTBURG, MD 60 W, MAIN STREET		
Balt	permit. Depertimport any Inj once.		21. Signature of Fu	mn -	CONCES	M6057	0	Name and Addre					
	Physician /Medical Examiner	Į.	23a. Part1. Enter to shock, or hea Immediate Cause disease or condition resulting in death) Sequentially list confiant, leading to in	irt failure. List oi (Final on	a. Frac Due to	ach line.	nip W uence of):	er the mode of dyir				ns	Approximate Interval Between Onset and Death
38760,	cate be executed physician and the burial-transit	dicai Examiner	rany, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	injury	c.	(or as a consequ				1.1		3 41.	
Box (Attending Physicien: The law requires that the death certifics relath. r death. ector: Atter this certificate has been signed by the attending pt by the funeral director, page 2 should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 [9 □ Unknown	months?	1 Live b	tcome of pregna pirth 2 Tetal pant at time of de pown	death 3	Ectopic pregnancy	,	A She		23d. Date of deliv Month	ery Day Year
d 'sp.	uires that n signed b ild be deta		Part II. Other signi	ficant condition	s contributing to d	eath but not resu	ulting in the u	nderlying cause giv	en in Part I.				the cause of death?
Division of Vital Records, P.O	. The law requir	Completed								24a. Was auto perfo 1 Yes	psy ormed?	death?	opsy findings available ompletion of cause of
Vita	ysicien: Th is certificete director, pag	To Be (25. Was case reference examiner?		Hospital:	Inpatient 2	ER/Outnatie	nt 3□ DOA Oth		ath (Check only		6 ☐Other (Speci	fv)
ion of	nding Physicien: ath. r: After this certific ie funeral director,		27. Manner of Deal 1 □Natural		28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury 212	f 28c. Injur		28d. Describe patie	how inju	ry occurred	
Divis	2550	Certification:	3 Suicide 4 Homicide	6 Could no determin	286. Place	of njury - tho	ome, farm, st Ome	reet, factory, office Frost	burg V	City or To	Street ar	nd Number or Run e) aylor (al Route Number, Cir F'burg
	he Hospital on 24 hours elle Funeral Dietely filled i	edicai	29a. Certifier (Check only one)		xaminer: On the b			h occurred at the til vestigation, in my o					
	Mithi To t	Σ	29b. Signature and	I title of certifier	alle			29c. Licens	26 907			ate signed (Month,	*
	10		30. Name and add		ihu, M.D.	, 925 B	ishop	Print) Walsh Dr	ive, Cum				1)
	Sta Regist		31. Date filed (Mor		32	Registrar's Signa	ture						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 1:00 P M March Sarah Louise Cox 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Doctor's Hospital Lanham, MD P.G. If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 8 / 24 / 27 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🗗 F 79 Attalla, 216-40-6972 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-4 show any highly or other traumatic event, the Medical Examiner must be notified at once. 1. Yes 2 □ No Director MD Riverdale Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7002 Furman Parkway 20737 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. Specify:Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Dietary Aide 8th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lela Bell Nathaniel Benson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7002 Furman Parkway, Riverdale, MD 20737 Carolyn Cunningham- Daught¢r 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Cemetary 3/22/07 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Reese Professional F.S. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3605 14th St., NW Wash., DC 20010 Approximate Interval Between Onset and Death **Physician** preumoni disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the bunal-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: , 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

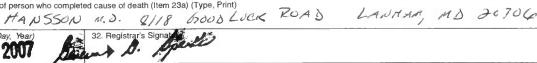
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar 31. Date filed (Month, Day, Year)

homas

29b. Signature and title of certifier

1/10MAS



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

MDD 53718

29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 24, 2007 D39255 Kas 30. Name and address of person who completed cause of d ath (Item 23a) (Type, Print) MD 20770 SUBBARAO 7207 HANOVER PARKWAY, SUITEB, GREENBLT, 31. Date filed (Month, Day, Year) MAR 2 7 2007 State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** JOSEPHINE CLARKE 2007 12:46 A.M MAR. /Medical 16, 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** SHADY GROVE ADVENTIST HOSPITAL GAITHERSBURG MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. T. (Month) Pay 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days SEP SEP 2 19, 1 ☐ M 2 🔀 F 80 210-74-5101 Director LIBERIA Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show "natural", or Items 23a or 28a-f shov edical Ex: miner must be notified at 1 ☐XYes 2 ☐ No Director MD MONTGOMERY GERMANTOWN 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 18412 STONE HOLLOW DR. 20874 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 □ Never Married 2 □ Married 1 □ Yes 2 No If Yes. Give 1 ☐ Yes 2 No BLACK Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 € Divorced Year or Dates: Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4Yrs <u>LAWYER</u> permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, til 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALFRED E. PRATT CATHERINE L. GREAVES ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18412 STONE HOLLOW DR., GERMANTOWN, Md. ERIC CLARKE/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) GATE OF HEAVEN CEM. 3-30-07 SILVER SPRING 21. Signature of Funeral Service License 22. Name and Address of Facility 20002 CAPITOL MORTUARY 1425 MARYLAND AVE., N.E. WASH.DC 23a. Part 1. Enter the disease of complications that caused the death. Shock, or heart failure. It is only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** FIC tp b /Medical Due to (or as consequence of): Examiner Sequentially list conditions, If any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine requires that the death certificate be executed burial-transi Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) P.O. signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, ģ Sion 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Tyes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ٩ nours after death.

neral Director: After this y filled in by the funeral di this 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ō within 24 hours a To the Funeral I To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death account of the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier NPC 9vch 16 2001 DAILeg

Registrar

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of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

PB221

31. Date filed (Month, Day, Year)

MAR 27 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 10:35^{P ™} Margaret V. Conway 21 2007 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Forest Glen Nursing Home Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days 1 M XX F 171-26-8551 84 Director April 15,1922 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d, Inside City Limits 1 TYes XX No Directo Maryland| Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 United States 12300 Viers Mill Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ∐ Yes 2**XX**No þ √2 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cook Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Albert Huey Goldie Huey ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Martha E. Fajardo-Daughter 12300 Viers Mill Road, Silver Spring, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Fort Lincoln Crematory 03/26/2007 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. En er the disease, or o mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o heart failure. List only one cause on each line. Immediat 2 ause (Final disease or condition resulting in death) THEROSCLEROTIC CARDIOVASCULAR DISCASE Unknown **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consectioned of Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by disease 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 4 hours after death. filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I

Division or Vital Records, P.O. Box 68760,

To the Hosp within 24 hor To the Fune completely fi

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 2 6

hardley

and manner stated

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15216 DINO DRIVE", BURTONSVILLE, MD 20866 CHOWD HURY, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 10:00 p^M March 21, 2007 /Medical Lawrence J. Capone 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 10806 E. Nolcrest Drive Silver Spring If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 X M 2 □ F Yrs. February 5, 1923 District of Columbia Director 577-24-0317 84 Usual Residence of Decedent be filed within 72 hours after death with the Maryland ntal Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 □Yes 2X No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 10806 E. Nolcrest Drive 20903 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: þ 3 Widowed 4 Divorced WUTT White Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int; If Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the C & P Telephone Co. 12 Installer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anne DiBari Joseph Capone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important; If Item 27 any injury or other tra Christine Capone - Daughter 10806 E. Nolcrest Drive, Silver Spring, Maryland 20903 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cheltenham Maryland State Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 3/27/2007 Veterans Cemetery Cheltenham, Maryland 22. Name and Address of Facility 21. Signature of Funeral Selvice Licensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or bright failure. List only one cause on each line. Imme late Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarction /Medical Due to (or as a consequence of) **Examiner** Coronary Artery Disease Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ò in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autonsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 124 hours after death.

■ Funeral Director: A pletely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 D D35162 March 23, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael S. Schindler, M.D., 10801 Lockwood Drive, Suite #200, Silver Spring, Maryland 20901 31. Date filed (Month, Day, Year) MAR 2 6 gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 012007 08:44 A M April Patricia M. Dudley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 75 578-42-0961 05/14/1931 Director Washington, D.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Marvland Anne Arundel Shady Side 1 ☐ Yes 2 ☑ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4928 Lerch Drive 20764 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No þ 3 NWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Moran Marian (Unknown) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Thomas Dudley/Son 1317 Butternut Street, Shady Side, Maryland 20764 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Arlington Nat.'1 Cem. 04/17/2007 | Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 21. Signature of Funery Service Licensee 2973 Solomons Island Road, Edgewater, Maryland 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the node of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician edical Due to (or as a consequence of) miner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4 □ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significarit conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Tes 2 No 3 Probably 4 □Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 2 **□**/No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No /I ☐ Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certif 29d. Date signed (Month, Day, Year)

State Registrar

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Thomas Dorsev 11:00p /Medical Clair March 23 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Arden Courts Kensington Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1**X**]M 2□ F 086-26-3459 69 Director April 2, 1937 New York Usual Residence of Decedent should be filed within 72 hours after death with the Maryland alth and Mental Hygiene.
27 is marked other than "natural" or "." traumatic event. ***...** 10c. City. Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 🔀 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10605 Penny Dog Lane 20902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 K Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Attorney Legal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any liury or other traumatic event one. Be Clair Dorsey Marjorie Duff 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Rosenberg/Companion 10605 Penny Dog Lane, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State Maple Grove Cemetery March 26, Frewsburg, New York 4 Donation 5 Dother (Specify) francis Addess Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 21. Signature of Funeral Service Licensee . Ken 23a. Port1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Alzheimer's Disease resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed and Due to (or as a consequence of) burial-1 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown 9 Unknown þ The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 XNatural 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

P.O. Box 68760. Division or Vital Records,

Hospital or Attending Physician: To the Hospital or

within 24 hours after death.

To the Funeral Director: After thi

State Registrar

Medical

31. Date filed (Month, Day, Year) MAR 26

Ava Kaufman, M.d

29b. Signature and title of certifier

29a. Certifier

(Check only one)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)





8218 Wisconsin Avenue, Bethesda, MD 20814

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D26259

29d. Date signed (Month, Day, Year)

March 24, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Richard Manuel Diaz 0100 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WMHS, Braddock Campus Cumberland **Allegany** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Aug. 25 9. Birthplace (State or Foreign 5. Social Security Numbe 215–18–8175 Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 17€74M 2□ F Months Days Hours 1920 Maryland 86 Aug. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a State 10c. City, Town or Location ir then "naturel", or iteme 23a or 28a-f ehow the Modical Examinar must be notified at Allegany MD. 1 Yes 2 No Luke Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 307 Pratt 21540 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1. Yes 2 No WW2 If Yes, Give Year or Dates: illad within 72 hours after 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 3 ☐ No ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filad within nant of Haalth and Mental Hygiana. ant: if item 27 is marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) US Postal Service Postmaster 12 other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alfred Josephine Alvarez Diaz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Diaz/ wife 307 Pratt St., Luke, Maryland 21540 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State parmit. Pages of Papartmant of Himportant: if ite eny injury or ot once. 1 ☐ Burial 25☐€remation 3 ☐ Removal from State 03/23/ Cumberland Maryland Cumberland Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home any 111 Church St., Westernport Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner fract in fection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a conseq nce of) Examine The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Box 68760, physician Physician/Medical tha for usa as attanding IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. datachad 4 s baan signad b should ba data Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an paga 2 has autopsy performed? cartificata 1 Yes 2X No or Attending Physicien: Aftar this cartification 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation daath. 1 Yes 2 No within 24 hours aftar daath To the Funeral Director: , completaly filled in by tha f 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospitai 1 Certifying Physician: To the best of my knowledge, death consumed at the time, date and place, and due to the nause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

3+114 State

Registrar

40 4 31. Date filed (Month, Day, Year)

euli MAR 2 3 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Ave Logacoaing, MAZING

JAMES CAGNEY Behard on. 07-02191 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Medical Examiner **JAMES** CAGNEY ECHARD, JR. 2352 hrs March 21, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3801 Cedar Croft Place Prince George's 5. Social Security Number **Funeral** 9. Birthplace (State or Foreign Washington 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (MM/DD/YYYY) If Under 24Hrs. Director Months Days Hours 216-94-8678 43 Country) DC 1 X M 2 F 12/26/1963 Usual Residence of Deceden ì 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show notified at once. 1 X Yes 2 No Maryland Prince George's hours after death with the Maryland Brentwood Director 10e Street and Number 10f. Zip Code 10g Citizen of What Country? 3805 Cedarcroft Place 20722 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 X Married White etc. Yes 2 X No 4 Divorced If Yes, Give Year Yes 2 X No specify. Specify: White \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) ind Mental Hygiene
7 is marked other than "ratic event, the Medical E College (1-4 or 5+) 1 and 2 should be filed within 72 MD 21215-0036 11 Independent Contractor Contracting 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) James Cagney Echard, Sr. Helen Yvonne Caldwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Echard - Wife 3805 Cedarcroft Place, Brentwood, Maryland 20722 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date tant: If it Burial 2 X Cremation 3 Removal from State crematory or other place) Metropolitan Crematory Donation 5 Other Specify 03/26/2007 Alexandria, Virginia Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MOIN91 MD 20781 **Physician** Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one gause on each line Between Onset and /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED physician the burial AMENDED The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month Day past 12 months? Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has death? performed? ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ this Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes No After 28a. Date of Injury (Month, Day Year) Mar 21, 2007 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural Subject pedestrian struck by train 2348 hrs 5 Pending 1 Yes 2 V No Director: 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 3801 Cedar Croft Place, Brentwood, MD (Specify) train tracks Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E March 22, 2007 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, State 32. Registrar's Signa Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** EKELCHIK DUEANNE 6:31 AM 2007 MARCH /Medical 16- City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and numb Examiner topkins "NONE" ITIMORE If Under 24 Hrs Hours Min. If Unde Months Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√2 F Days 140-30-5587 68 JULY 17, Director 1938 NEW JERSEY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d, Inside City Limits 1 TYes 2 TXNo Director FLORIDA PALM BEACH BOYNTON BEACH 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 A EASTGATE DRIVE Funeral USA 33436 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No WHITE Specify Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATOR SALES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SAMUEL COOPERMAN DOROTHY RIEFF 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACOB EKELCHIK/HUSBAND 13 A EASTGATE DRIVE, BOYNTON BEACH, FLORIDA 33436 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 ☐ Cremation 3 ☐ Removal from State MT. SINAI CEMETERY 03/27/2007 4 Donation 5 Dother (Specify) MARLBORO, NEW JERSEY 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS NINETY DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine executed burial-transit Due to (or as a consequence of): Box 68760 attending physician death certificate be Physician/Medical the as IF FEMALE: for use a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9□Unknown 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 1 TYes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1□ Yes 2/No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) ne Hospital or Attending P 124 hours after death. ne Funeral Director: After the 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: 5 Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

egistrar MAR 2 6 200

31. Date filed (Month, Day, Year)

AVERBACH



M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RES-000

BALTIMORE

21287-9106

		1 - For State Registrar		-	Certificate of		Re	g. No.?	11164		
Physic	ian	1. Decedent's Name (First, Middle, ARCHIE EDIA	IGTON				2. Date of Death Month	Day Year			
/Med Exam		4a. Facility Name (If not institution,			4b. City, Town,	or Location of Death	03	21 07 4c. County of De			
	illei	Anne Arundel Med	dical Center	r	Anna	polis		Anne A	rundel		
Funera Directo		577-14-0783	S.Sex 7.Ag 12⊈M 2□F	85 Yr	day) If Under 1 Yea		8. Date of Birth (Month, Day, 5/7/1921		nthplace (State or Foreign Country) abama		
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits		
he Mary	ector	MD Anne An	runde1	Annapo1					1x Yes 2 No		
th with the 23a or 2	Funeral Director	10e. Street and Number 603 A Admiral Di	· #101		10f. Zip Code 214	401	10	g. Citizen of What C USA	Country?		
Iryland 21215-0036 should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23s or 28s-1 show mails event, the Medical Exertirer mails event, the Medical Exertirer mail the notified at	b	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 🖎 Yes 2 🔠 If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2X No		pecify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh Specify: Wh	ite, etc.		
Maryland 21215-0036 of 2 should be filed within 72 hours at the and Mental Hygiene. 27 Is marked other than "natural", or traumatic event, the Medical Exert traumatic event, the Medical Exert	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5	(9	ecedent's Usual Occu Give kind of work don ife. DO NOT use retir	upation e during most of work ed)	ang 1	6b. Kind of Busines	s/Industry		
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aryland should be I and Mental I marked o	2	Archibald Mathev 19a. Informant's Name/Relationshi		10b A	Mailing Address (Stree		ora Pipp:		Zie Cada)		
re, Maryla s 1 and 2 should f Health and Men tem 27 Is marke other traumatic		Doris Edington	Wife		A Admiral						
e He He He		20a. Method of Disposition 15 Burial 2 ☐ Cremation 3		20b. Place of D cemetery,	disposition (Name of crematory or other pl	ace)	Date 2	Oc. Location - City of	r Town, State		
Baltimol permit. Pages Depertment of Important: If I eny injury or e		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li		Marylan	d Vet Ceme	etery 3/2/					
B Per		> fangh		_	12 Ridgely				e, r.A.		
Physician /Medica		23a. Part 1. Enter the disease, or c shock or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	niy one cause on each li	the death. Do no no. whented a consequence of	Asysta	ring, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death		
Examine		Sequentially list conditions,	. Ca	rdiany	spathy						
cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	Coron	a consequence of	Em 12:30	ease					
68760, rifficate be executed og physician and as the burial-transit											
rtifical ng phy	Medical	IF FEMALE:									
at the death cert by the attendin	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnan 5 □ Other (specify)	су		23d. Date of d Month	elivery Day Year		
S, the street of de	þ	Part II. Dther significant condition Hyperchyle 5	s contributing to death b	ut not resulting in t	he underlying cause g	pven in Part I.			to the cause of death?		
COLD: w require been signal	Completed	Michadusal	1410			•	24a. Was an	24b. Were a	autopsy findings available		
The lav	omo	The state of the s					autopsy perform	ed? prior to	completion of cause of		
	0	25. Was case referred to medical	Lewin	/		26. Place of Deat	1 ☐ Yes 2 th (Check only one		s 2 No		
G =	To B	examiner? 1 Yes 2 No	Hospital: 1 Dinpatie	int 2 ER/Outp	atient 3 DOA	ther		nce 6 Other (Sp	ecify)		
DIVISION Of VITA or attending Physicien: effer deeth. Director: After this certification by the funeral director.		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Inju (Month, Da	ry 28b. Tin y Year) Inju	ury W	ury at ork?	28d. Describe how	w injury occurred			
등 함께 등	Certification;	3 Suicide 6 Could no determin		ury - At home, farm c. (Specify)	n, street, factory, office	•	28f. Location (Street) City or Town,	eet and Number or I State)	Rural Route Number,		
To the Hospital within 24 hours e To the Funeral I completely filled	edical (29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best caminer: On the basis o and manner sta	examination and/	death occurred at the or investigation, in my	time, date and place, opinion, death occur	and due to the car red at the time, da	use(s) and manner a te and place, and di	as stated. ue to the cause(s)		
To the within 2 To the complet	W	29b. Signature and title of certifier	2 C U			1034	29	d. Date signed (Mor	nth, Day, Year)		
		30. Name and address of person w	ho completed cause of d	eath (Item 23a) (T	1/2	7 1107		03,21,	Lov T		
104		LAURIA, 128	LUBRANO Z	RIVE SU	ITE 300 /	ANNAPOLIS	MD 2	1401			
S Regis	tate :	31. Date filed (Month, Day, Year)	3 2007 32. Registr	ar's Signature	A						
DHMH 17 Rev 1				year for	Cont.						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month April 3 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2007 Year 3 Treva Diane Ford 6:20 p.

4b. City, Town, or Location of Death

4c. County of Death

Physician /Medical Examiner

1 - For Stete Registrar

4a. Facility Name (If not institution, give street and number)

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depurtment of Health and Mental Hyglene. Importent: if item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other treumatic event, it a Medical Examinal must be retitined at ODE.

Baltimore, Maryland 21215-0036 Physician /Medical **Examiner**

attending physician and for use as the burial-transit

To the Hospital or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funsral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached to

	Citizens Nursing H			Freder				derick			
	5. Social Security Number 6. Sex	1 25√F	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 H	n. (Month, Da)	h v. Year)	Coun			
	218-76-0117 Usual Residence of Decedent	4	8 '''s.			Feb. 17	, 1959	Mar	yland		
	10a. State 10b. County	10	c. City, Town or Lo	or Location 10d. Inside City							
tor	Maryland Frederic	:k	Myersvil	.1e				1 □ Yes 2√0XNo			
irec	10e. Street and Number			10f. Zip Code		10g. Citizen o		itry?			
al D	3438 Brethren Churc	:h Road		2177	3		USA				
nei	11. Marital Status	. Was Decedent Ever Armed Forces?		Vas Decedent of H Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- orto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.				
Completed by Funeral Director	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:		Spec	ily: Whi	te		
etec	15. Decedent's Educa (Specify only highest grade of	tion completed)	16a. Deced (Give	lent's Usual Occup	ation during most of w	orking	16b. Kind of	Business/Inc	dustry		
mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	00 NOT use retired Washer	d) -		Restau	irant			
ပိ	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)										
To Be	Darrell William For	·d				Virginia					
1	19a. Informant's Name/Relationship (Type	, Print)	19b. Mailin	g Address (Street	and Number or	Rural Route Numbe	r, City or Tow	m, State, Zip	Code)		
	Patsy V. Ford / Mot	her	3438	Brethren	Church	Road, My	ersvil	le, Ma	ryland 217		
	20a. Method of Disposition		Ob. Place of Dispo			Date	20c. Location				
	1 🛱 Burial 2 ☐ Cremation 3 ☐ Rer '4 ☐ Donation 5 ☐ Other (Specify)	noval from State	Harmony (6, 2007	Myers	ville,	Maryland		
	21. Signature of Funerel Service Lich see	i i	22	. Name and Addre	ss of Facility	504	Main	Street	t		
	Jafa Juli	es	R	icketts I	uneral	Home Mye	rsvill	e, MD	21773		
	23a. Part1. Roter the disease, or complica shock, or heart failure. List only one	tions that caused the cause on each line.	death. Do not ent	er the mode of dyir	ng, such as card	ac or respiratory ar	rest.		Approximate Interval Between		
Ž į	Immediate Cause (Final disease or condition	Resp	ritory	Fail	me				Onset and Death		
	resulting in death)	Due to (or as a	onsequence of)		101907						
L	Sequentially list conditions, b.	Sevi	ve s	leep a	porce	Ĺ			years		
lue	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dies to (or as a co	maequence orp:	her L			1/20 1				
xan	that initiated events c. resulting in death) Last	Due to (or as a co	onsequence of):	SIJU	}				gens		
by Physician/Medical Examiner	d.				1						
Medi											
an/N	23b. was decedent pregnant	: If yes, outcome of p		Ectopic pregnance	,			Date of delive	,		
sici	in the past 12 months?	4☐Pregnant at time 9☐ Unknown		Other (specify)			ľ	Month	Day Year		
Phy	9 Unknown					na Dida			and an analysis of depth?		
	Part II. Other significant conditions contr	buting to death but he	ot resulting in the ui	nderlying cause giv	en in Paπ I.				ne cause of death?		
Completed			****								
mple						24a. Was autop		b. Were auto prior to condeath?	psy findings available mpletion of cause of		
						1 ☐ Yes	2)(No		2 □ No		
Be	25. Was case referred to medical examiner?	spital:			on A	eath (Check only o					
. To	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatien	1 3 DOA	Nursing	Home 5 ☐ Resid			у)		
tior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ear) Injury	Wo	k? Yes 2∐No		. ,				
ifica	3 Suicide 6 Could not be	28e. Place of Injury	At home, farm, str	eet, factory, office				mber or Rura	al Route Number,		
Sert	4 Homicide	building, etc. (5	ореспу)			City or Tov	vri, Stafe)				
Medical Certification:	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of m	amination and/or in	occurred at the ti restigation, in my	ne, date and pla ppinion, death oc	ce, and due to the curred at the time,	cause(s) and date and plac	manner as si e, and due to	tated. the cause(s)		
Me	29b. Signature and title of certifier	0		29c. Licens	e number		29d. Date sign	ned (Month,	Day, Year)		
	-	4-		243	1091		4-1	4-07			
	30. Name and address of person who com			Print)	1 .			- '	CK MO		
	Sacred Car	ndi m	1) 8	501 TOL	L Hon	n Ave	, 5	coleri	ck MO		

State Registrar

31. Date filed (Month, Day, Year)

APR 0 9 2007

32. Registrar's Signature

07-02150

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Lamar D. Fleming	1- For State Registrar	ate of Maryland	Certificate		i ivientai H	, ,	g. No. 200	7 1116
Physician/ Medical Examine		·	EMING			2. Date of Death Month March 19,	Day Year	3. Time of Death 2330 hrs
	4a. Facility Name (if not institution	on, give street and number	r)	4b. City, Town, or L	ocation of Death		4c. County of De	
Suppose	906A Royal Street 5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthday)	Annapolis If Under 1 Year	If Under 24Hrs	I Date of Birth	Anne Aruno	
Funeral Director	577-48-0599	1 M 2 F		Months Days	Hours Min	_	Fo	reign Country) Md.
any	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Loc	ation		-		10d Inside City Limits
daryland 28a-f show 1 at once. ector	D.C.		W	ashington				1 X Yes 2 No
the Maryland a or 28a-f sh tiffed at once	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	
with th	2300 Raynolds 11. Marital Status	12. Was Deceden		Vas Decedent of Hisp	020 panic Origin? (Si	pecify Yes or No-	United 14. Race - An	States nerican Indian, Black,
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 X Never Married 2 M 3 Widowed 4 Div	arried Armed Forces 1 Yes 2 vorced If Yes, Give Year or Dates:	s? If 2 🕱 No	Yes, specify Cuban, Yes 2 X No		Rican, etc.)	White, etc.	Black
hours aft natural" Examine	15. Decedent's Education (Spe	cify only highest grade co	during	ent's Usual Occupation			16b. Kind of Busine	ss/Industry
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	Labore			Pr	ivate
5-00 led with tygien other the Me		, Last)				e (First, Middle, M		17466
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cevent, the Medica To Be Comple			Lagi. Mail:	Address (a)		lene Flo		
and 2 should and 27 is ma traumatic every	Marlene Flemi		1	ng Address (Street Raynolds			sh., DC	20020
re, N and Healti f item	20a. Method of Disposition		20b. Place of Disp	osition (Name of ceme		Date	20c. Location - City	
Baltimore, permit. Pages I ar Department of Hee Important: If ite	1 X Burial 2 Cremation 4 Donation 5 Other S		riate	oln Cemete	ery 3-2	27-07	Brentwe	ood, Md.
Baltimore, MD 21215-005 permit. Pages I and 2 should be filled withi Department of Feath and Mental Hygiene Important: If item 27 is marked other ti injury or other traumatic event, the Med	21. Signature of Funeral Service		11. 11.	Name and Address	Car		rtuary, I	
Physician	28a. Part I. Enter the disease or	complications that cause		425 Maryla the mode of dying, s			wash., DC st, shock, or heart	20002 Approximate Interval
/Medical Examiner	failure. List only on suse Immediate Cause (Final discussion condition resulting in death)	M. Wash Co. and						Between Onset and Death
ے ا	Sequentially list conditions,	b						
ted sinsit	if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated	C.						-33
ecuted and transit	events resulting in death) Last	Due to (or as a cons	sequence of):					
760, cate be execut physician and he burial - tra	UNPENDED	AMENDED					Table 1	
Division of Vital Records, P.O. Box 68760, fo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burtal - transit edical Certification: To Be Completed by Physician/Medical Executed.	IF FEMALE: 23b. Was decedent pregnant in t past 12 months?	LIVE DITTI	2 F	Fetal death 3 Other (Specify)	Ectopic pregna	ancy	23d. Date of deliv	Day Year
that the done by the detached by Phy			ith but not resulting in the	e underlying cause giv	ven in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
s, P.C ires that signed the deta						1 Yes	2 • No 3 F	Probably 4 Unknown
Division of Vital Records, P.O. tat or Attending Physician: The law requires that the rs after death at Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P						24a. Was a autops perforr	y prior ned? death	
Vital Recysician: The list certificate lidirector, page		Henrital:			of Death (Check			
of Vit	1 Yes 2 No	28a Date of Ini	ient 2 ER/Qutpatie				Residence 6 🗸 01	ther: Scene
on of ending Pl ath or: After he funeral tion: T	1 Natural 5 Pen	ding FOUND: Day	FOUND:		es 2 🗸 No	Subject shot		
Division o spital or Attending tours after death neral Director: Aft filled in by the fune Certification:	2 Accident Inve 3 Suicide 6 Cou 4 Homicide		Injury - At home, farm, str	reet, factory, office bu	ilding, etc.	or Town, Sta		Rural Route Number, City
Division of To the Hospital or Attending Physitin 24 hours after death To the Funeral Director: After tecompletely filled in by the funeral Medical Certification: T		hysician: To the best of r iminer:On the basis of exe and manner stated	amination and/or investig					
E S F S E	29b. Signature and title of certifi		\cap	. 29c. License			29d Date signed (
	Card	Hall	Lau	O.C.W	1.E.		March 20, 200	
R(4)	30. Name and address of person Carol Allan, MD As	n who completed cause of sistant Medical Exa	·	Street, Baltimo	re, MD 2120	11		
State		.32. Registr	ar's Signature	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9:33A M Karla Farrall March 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Doctors Community Hospital Lanham Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/08/1950 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 □ M 2 □ F 579-71-7107 57 Director Washington Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1. Yes 2 No MD Prince Georges New Carrollton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country's ö 7613 Fontainebleay Drive 20784 United States or Items 23a Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: ģ 3 ☐ Widowed 4 ☐ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed wi Health and Mental Hygien Im 27 is marked other th Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Fortun William L. Schallert ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20784 Department of Health a Important: If item 27 is any Injury or other tra Robert Farrall/Husband 7613 Fontainebleau Drive New Carrollton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan 3/25/07 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Greene 21. Signature of Funeral Service Licensee Home nia 22314 814 Franklin 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic Immediate Cause (Final reast Cancer **Physician** 2 yrs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner patic 2 WKS Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be execute burial-tran and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical use as the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 9□Unknown Year Day 5 ☐ Other (specify) P.O. I signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performed certificate 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA P After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After Certification: 5 Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 1 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20058213 Harbay 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARHAD JAMALI, 7305 Hanover PKWY Greenbelt MD 20770 32. Registrar's Signatur

DHMH 17 Rev 1/2001

State Registrar

/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Box 68760 P.O. F Division of Vital Records,

RT

Physician

anding physicien and use as the burial-transit . After this certification. s efter des. rei Director: Afte filled in within 24 hours e To the Funers! C

this certificate

Physician

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permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23e or 28e-1 ehow any njury or other traumatic event, the Madical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease of the years Examine resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Completed 25. Was case referred to medical examiner? Be Certification: To 27. Manner of Death Natural 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0063730

State Registrar

NAMITA

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TULI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, UNION ELICTON HOSPITAL. 32. Resistrar's Signature Server

MID

			1 _ State	aryland /	Department			-	- 9	007	1116
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate	e or De	eatri	2. Date of De	Reg. No.	001	3. Time of Death
	Physici	an	\mathcal{M}	G_{ν}	~ 11.			Month	Day	Year	4:30 P M
	/Medic Examir		4a. Facility Name of not institution, give street and number		4b City	Town orton	cation of Death	March		ounty of Death	4170 7
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	Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last b	irthday) If Under	1 Year If	Under 24 Hrs.	8. Date of Birt	th	Garret 9. Birthp	lace (State or Foreig
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	aryla •ho	ሯ	MD		wn or Location					1	0d. Inside City Limits 1 X Yes 2 ☐ No
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	with	급	201 E Mason St. # 17		10f. Zip				10g. Citize	n of What Coun	itry?
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(0	r iter	Fun	Armed Forces 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑	?	If Yes, spec	fy Cuban, N	Mexican, Puerto	Rican, etc.)		Black, White,	
ဗ္ဗ	al', o	by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2	No S	Specify:		S	ресіfy: Wh	ite
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altimore,	그 문문을 .		21. Signature of Funeral Service Licensee	Ошева	a Cremato 22. Name and	_	3/20 f Facility S1			ntown, al Home	
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<u> </u>	The page	5	2) Atrial forlation and con	made 1	clea	Ta.	LIA	perfo	rmed? 2 ☐ No	death? 1 ☐ Yes	
Vita	lcian Sertifi ector	Be	25. Was case referred to medical examiner?				Place of Death	(Check only o	ne)		
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Division of Vital Records,	Atten deat ctor: y the	flca	3 Suicide 6 Could not be 28e Place of In	iurv - At home, f	arm, street, factory,			28f. Location (S	Street and h	Number or Rural	I Route Number
2	efter Direct Direct	Certification;	4 Homicide determined building, e	c. (Specify)	,			City or Tow			
	pspltt hours unere ly fille		29a. Certifier 1 Certifying Physicien: To the best	of my knowledg	e, death occurred a	t the time, d	date and place, a	and due to the	cause(s) ar	nd manner as st	ated.
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours efter death. To the Funerel Director: After this certificate hes been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) 2 Medical Examiner: On the basis of and manner st	of examination ar	nd/or investigation,	in my opinio	on, death occurre	ed at the time, o	date and pl	ace, and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of dentiler		29c.	License nui	mber		29d. Date s	signed (Month, L	Day, Year)
			Manh Hald MD.			14	1925		3/	19/07	
		5	30. Name and address of person who completed cause of	path (ttem 23a)	(Type, Print)						
	Sta	7	31. Date filed (Month, Day, Year) 32. Begist	ar's Signature	Mynd	219	550				
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DHMH 17 Rev 1/2001

State

Registrar

MAR 2 3 2007

			For State Registrar		State of Ma	ryland /	•	artment o				Reg	g. No	007	11170
	. Physici	an	Decedent's Name	-							2.	Date of Death Month 3/22/07	Day	Year	3. Time of Death 7:50A M
	/Medic	al	Wilda	Eleanor:	a Gond	er		4b. City, To	wn orl	ocation of I	Death	3/22/07		ounty of Death	
	Examin	er			r Nursing	Home			k1aı		Joann			arrett	
£.	Funeral		5. Social Security N	lumber 6. S	ex 7. Age	(In yrs. last b	oirthday)	If Under 1	Year	If Under 24	Hrs. 8.	Date of Birth (Month, Day,)		9. Birth	place (State or Foreign
	Director		216-14-19	908 1	□ M 2 💢 F	82	Yrs.	Months (ays	Hours		8/25/19			7land
	D *		Usual Residence of 10a, State	Decedent 10b. County		10c. City, To	wn orlo	cation							10d. Inside City Limits
	Aaryla Pool	ō							a a						1 X Yes 2 □ No
	28a-1	Director	MD 10e, Street and Nur		rett	,		Oaklan				10	g. Citize	n of What Cou	intry?
	3a or		820 E. Hi						1550)				ī	J.S.A.
	death ms 2	Funeral	11. Marital Status	-0	12. Was Decedent E Anned Forces?	ver in U.S.	13.	Was Deceder	nt of His	panic Origin	n? (Specif	y Yes or No-	14	Race - Ameri Black, White	ican Indian,
	72 hours after death with the Maryland "natural", or Itama 23a or 28a-f ahow oldest Endminer must be notified at	þ	1 ☐ Never Marri 3 ☑ Widowed	ied 2□ Married 4 □ Divorced	1 Yes 2 N If Yes, Give Year or Dates:	0		1 ☐ Yes 2X		Specify:	dello i lic	an, oto.,	S	pecify:	White
Maryland 21213-0030	72 ho natur	Completed	(Spec	15. Decedent's Ec	lucation	16	a. Dece	dent's Usual (Occupat	ion	of working	11	6b. Kind	of Business/li	ndustry
-	S 3	nple	Elementary/Seco		College (1-4or 5	+)	lite.	DO NOT use	retired)	, ,,, goo. o	, working				
i	filed with Hygiene. Ither ther	So	12					House			- 11 //	First, Middle, M.		Home	
	b la b	Be		(First, Middle, Last)	Nethken					Grace	,	Mollie		Bolya	n d
	d 2 should the and Menity of the market traumatic	10	Nelson	Adam ame/Relationship (9b Mailir	ng Address (Street ar			Route Number,			
3	128			nder/ Son	, , , , , , , , , , , , , , , , , , , ,							MD 217			, , , , , , , , , , , , , , , , , , , ,
	s 1 and 2 if Health Item 27 other tra		20a. Method of Dis					sition (Name matory or oth		-	Date			ation - City or T	own, State
2	00			☐ Cremation 3 ☐ 5 ☐ Other (Specify	Removal from State	_		Cemet			/25/0	7 C	ak1	and, MI)
	permit. Pag Department Important: f any injury o			uneral Service Licer			22					art Fur Oakland			
			23a, Part1, Enter t	the disease, or com	plications that caused	the death. De	o not ent							21330	Approximate
	Physician /Medical Examiner		shock, or hea Immediate Cause disease or condition resulting in death)	(Final	a. acy to Due to (or as b. atheros	a consequenc	D C	ordiol	i	n force	tion.	a a? da 9			Interval Between Onset and Death LL hours
	uted d ansit	Examiner	Sequentially fist co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	injury	b. Due to (or as	a consequenc	ee of):	Cavar	2007	C 4 (0)	r 411	1000	<u>.</u>		Years
,0070	Physician: The law requires that the death certificate be executed this certificate has been signed by the ettending physician and rail director, page 2 should be detached for use as the burial-transit	cal	resulting in death)		Due to (or as	a consequenc	e of):								
200	leath certificate t ettending physicater of the user as the total	an/Me	fF FEMALE: 23b. Was deceden		23c. ff yes, outcome 1⊡Live birth		ith 3	Ectopic pred	nancy				23	d. Date of deli	•
5	that the deat led by the ett detached for	Physician/Med	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	No	4∐ Pregnant at 9☐ Unknown			Other (spec						Month	Day Year
,	es tha igned be det	by P			ontributing to death b		in the u	inderlying cau	ise give	n in Part I.		23e. Did toba	acco use		the cause of death?
3	w require been signature	pe	dem	en tio,	se nite o	user					_	1 🗆 Yes	s 2 /3	No 3 □ Pro	obabły 4 Dunknowr
חבכם משי	e law n hes be ge 2 sh	ple									_	24a. Was an	/	prior to c	lopsy findings available completion of cause of
	The ate h page	Completed										perform 1 Yes 2	2No	death? 1 ☐ Yes	2 🗆 No
O VIII	ysician: The l is certificate he director, page	Be	25. Was case reference examiner?	rred to medical	14						of Death (Check only one)		
5	Physi this o	은	1 Yes 2			nt 2 ERV				4 Nurs		5 🗆 Resider			cify)
	ding h. Aftel fune	atlon	27. Manner of Dear	5 Pending investigation		Year)	D. Time o Injury	M 281	Work	es 2 N	0				
DIVISION	or after Dira	27. Manner of Death 1 Natural 2 Accident sinvestigation 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 Yes 2 28c. Injury at Work? 1 Yes 2									28	f. Location (Str. City or Town,		Number or Ru	ral Route Number,
	To the Hospital or A within 24 hours after To the Funers! Dirac completely filled in by	Medical	29a. Certifier (Check only one)		nysician: To the best niner: On the basis of and manner sta	examination									
	To ta withi To th	¥	29b. Signature and	d title of certifier	lanon	~	M	D D C	License 20	number Z 5	759	N 29	1 <i>U+C</i>	signed (Monti	1. Day, Year) 2007
		10	30. Name and add	tress of person who	completed cause of d	eath (Item 23	a) (Type,	Print) P. O. B	8 ×	24	7. A	ccide	nt	MD	2007
	St Regist	ate rar	31. Date filed (Mor	nth, Day, Year)	32. Registo	y's Signature	- Afterior	A	**						
DH	MH 17 Rev 1/2			MAR 2	3 2007	De huce	And .	A Marie Artis	14.50						

ORIGINAL

			For State of Ma		artment of Health artificate of Deat		Hygiene Reg. No	0000	parts and a second	7 1				
Ė			Decedent's Name (First, Middle, Last)			2. Date of	Death	2001	3. Time of D	Death				
	Physicia /Medic		Rodney Charles Good			March	1 25 Da	200 ⁷	1:35	Ам				
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location		4c. County of Death							
			VA Maryland Health Care Sys		Perry Poin		Dist	Cecil	d					
	Funeral Director		196-10-8235 1\\ \frac{1}{3}\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	88 Yrs.	Months Days Hours	Min. (Month.	Day, Year) Co	thplace <i>(State or l</i> buntry) nsylvania					
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City	/ Limits				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	Maryland Cecil	Charles	town				1 X ∑XYes 2	2 🗌 No				
	ith the	Dire	10e. Street and Number		10f. Zip Code		10g. Ci	itizen of What Co	ountry?					
	s 23a	Funeral Director	108 Edgewater Avenue	in II 0	21914	2: :-0 (2 : //)		ted Stat						
	item item	-une	11. Marital Status 12. Was Decedent E Armed Forces? 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ N	verin U.S. 13.	Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	origin? (Specify Yes or can, Puerto Rican, etc.)	No-	Black, Whit						
98	urs af al", or Exam	ģ	1 □ Never Married 2 □ Married 1 □ TYes 2 □ N 3 □ Widowed 4 □ Divorced 1 □ Tyes, Give Year or Dates 1	941-45	1 ☐ Yes 2 ☐ No Specia	fy:		Specify:	White					
20	72 ho 'natur dical l	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupation e kind of work done during m DO NOT use retired)	ost of working	16b. F	Kind of Business	Industry (
21215-0036	vithin ene. than "	Completed by	Elementary/Secondary (0-12) College (1-4or 5-	+) _	ne Operator	·	C	onstruct	do-					
	filed v Hygid	ပိ	17. Father's Name (First, Middle, Last)	- CLai	-	ther's Name (First, Mic			1011					
Maryland	Ild be Tental rked c	To Be	J. Rodney Good		Agr	nes Dietle								
ary	shou and N		19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ing Address (Street and Nun	nber or Rural Route Nu	ımber, City	or Town, State, 2	Zip Code) 219	914				
	and 2 lealth m 27 her tr		Betty J. Good / Wife	P.O.	Box 162,108 1	Edgewater A	Avenue	e, Charl	estown,					
101	iges 1 nt of F if ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State		osition (Name of ematory or other place)	March		ocation - City or	·					
Baltimore,	nit. Partmer artmer ortant Injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Censee		Crematory 22. Name and Address of Fac	26, 2007		ark, Del	aware					
Ba	permi Depai Impoi any Ir		Wall Comment		27 South Main	Grouch		al Home East, M	arvland2	1901				
ſ	Mag.		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin						Approximate Interval Between					
6	Physician		Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease unknow Due to (or as a consequence of):											
7	/Medical Examiner		resulting in death)		A 1				_					
	A-40 A	F	Sequentially list conditions, if any, leading to immediate b. Hyperten Due to (or as a	sion consequence of):					unknown					
	uted d ansit	Examiner	cause. Enter Underlying	Type II					unknown					
oʻ	exec an and rial-tra	Еха	U	a consequence of):										
68760,	icate be executed physician and s the burial-transit	edical	d											
	± 00 %		IF FEMALE: 23c. If yes, outcome	of programmy										
Box	death certific e attending pl d for use as t	Physician/M	in the past 12 months?	2 ☐ Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month		ear				
P.0.		ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	anno or goddin										
	s that gned b	by Pi	Part II. Other significant conditions contributing to death but	t not resulting in the	underlying cause given in Pai	rt I. 23e. D	id tobacco	use contribute to	the cause of dea	ath?				
ord	w require been sig should b	ed t	Vascular Dementia			1	☐ Yes 2	2 □ No 3 □ P	robably 4 Un	nknown				
ecc	B 55 Cl	Completed	Cellulitis Right Lower Ext	remity		а	Vas an utopsy	prior to	utopsy findings av completion of cau	vailable use of				
a H	i cian : The l certificate ha ector, page					1 Y	erformed? es 2 N	death? o 1 ☐ Yes	2 □ No					
Division or Vital Records,	Physician: r this certific ral director,	Be o	25. Was case referred to medical examiner? 1 Types 2 TO No. Hospital: 1 Types 1 Types 2 TO No.	at a CIED/Outpatia	l Out-	ice of Death (Check or								
ō	iding Physician: h. After this certifica funeral director, p): To	27. Manner of Death 28a. Date of Injur	y 28b. Time	ALL SELECT	Nursing Home 5 F		6 ∐Other (Spe ury occurred	cify)					
ion	ath. ar: Aft	atio	1 XX Natural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	Year) Injury	M 1 Yes 2	□No								
<u>ivi</u>	or Attending after death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of inju	ry - At home, farm, s . (Specify)	treet, factory, office	28f. Location City or	n (Street a Town, Stat	and Number or Rite)	ural Route Numbe	er,				
	pital or urs af eral D		On Continue AFT Continue Physics To the bank	facilization des	ble a commend at the stime of the									
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner sta	examination and/or i	nvestigation, in my opinion, c	and place, and due to leath occurred at the ti	me, date ar	s) and manner as nd place, and du	s stated. e to the cause(s)					
	To the within To the compl	Me	29b. Signature and title of certifier		29c. License numbe	r	29d. Da	ate signed (Mon	th, Day, Year)					
)			Shen & Hash	mi M	D24648		3/:	25/07						
/	7+1VA		30. Name and address of person who completed cause of de Sher A. Hashmi, M.D. VA Ma	eath (Item 23a) (Type aryland He	, Print) alth Care Sys	tem Perry	Point	t, MD 2	1902					
	Sta	te		r's Signature	_									
	Desire	ar	MAR 2 7 2007 Beaut.	15 GOB4										
	Registr		- COOL CONTRACTOR											

State of Maryland / Department of Health and Mental Hygiene

1 - State AmendPI, perME, g867, 5/10/07 TT
Registra Amend#25. & 27. PerMERCC3-27-07cr

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Margaret Bertha Hospan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Prince George's Lanham If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 X F 323-18-1896 93 Director Mar. 29, 1913 Chicago, Illinois Usual Residence of Decedent 10b. County 10c. City, Town or Location r 28a-f show notified at Funeral Director Maryland Prince George's Largo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ns 23a must b 202 Prenton Street 20774 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced Item 27 Is marked other than "nature other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
|Daycare - PG County 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dept Agric.-Log Cabin 12 Daycare Provider / Cook Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file iment of Health and Mental Hitant: If Item 27 Is marked oth Be Unknown ၉ Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Hospan - Son 202 Prenton St., Largo, MD 20774 timore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State = 5 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Department o Important: If any Injury or Metropolitan Crematory Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 3/26/07 21. Signature / Funeral Service License 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. N61491 Hyattsville, MD 20781 a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ganarems **Physician** /Medical Due to (or as a consequence of); Examiner vem 4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed and burial-trar Due to (as a consequence P.O. Box 68760, physician Physician/Medical miline as IF FEMALE use 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an autopsy performed? Yes 2 No certificate 1☐ Yes Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Year

2007

40.

Birthplace (State or Foreign Country)

White

10d Inside City Limits

Approximate Interval Between Onset and Death

whis

Year

Day

28d. Describe how injury occurred

28f. Location (Street and Number or Bural Route Number. City or Town, State)

Dome

1√F Yes 2 □ No

Certification; To or Attending 24 hours after death. ■ Funeral Director: A filled in by hom 14 our Care Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00058213 tarhad FARHAD JAMALI MD. 7305 Hausever PKWY Creentest MD 20770 31. Date filed (Month, Day, Year)

28a. Date of Injury

State Registrar

MAR 27 2007

1 X Yes 2 100

5 Pending

investigation 6 Could not be determined

27. Manner of Death

2 X Accident

3 ☐ Suicide

4 ☐ Homicide



this

After

2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28b. Time of

28a. Date of Injury
(Month, Day Year)

28b. Time of Injury
Wo
1

28c. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month Day 0850 M **Physician** 9914 17 arriso ~ Mar 300 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital 8. Date of Birth (Month, Day, Year) Dec. 25, 19 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 XF Virginia 98 1908 579-34-3557 **Director** Usual Residence of Decedent 10c. Cify, Town or Location 10d. Inside City Limits 10a. State 10b. County ms 23a or 28a-f shor must be notified at 1X Yes 2 No Director DC Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20011 USA 601 Oneida Pl N. W. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3 X Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than "vent, the Mer Elementary/Secondary (0-12) College (1-4or 5+) Domestic Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental Important: If item 27 is marked or any Injury or other traumatic eve once. Hester unk Luther Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 617 Oneida Pl. N.W. Washington, D.C. 20011 Vivianne Mozon/Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 3-26-2007 Suitland, Md. 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery re of Funeral Service Licensee 22 Name and Address of Facility
Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, D.C. Approximate Interval Between Onset and Death art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in death) Renal **Physician** mo pmE /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a conseque Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 2X No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No Certification: To 28b. Time of 28d. Describe how injury occurred from 542111-28a. Date of Injury (Month, Day Year) 27. Manner of Death Injury at Work? 1 Natural 5 Pending investigation Stuheel chair to bed 3/0 1 🗌 Yes Mer 14 2007 neral Director: / r filled in by the fi 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) >50; MUS GROVE RD 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Nurging Sluce Poring 20904 Nome mo within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State MAR 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

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Md.

Funeral

Director

item 27 is marked other than "natural", or Itama 23a or 28a-1 show other treumatic event, the Medical Examiner must be mailfied at

with the Maryland

death

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

nd Mental Hygie marked other t

Depentment of I

Baltimore, Maryland 21215-0036

ettending physicien and for use as the burial-transit ed by the e pe should peen page 2 has certificate within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral

ian/Medical

Be

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Certification:

Medical

Division of Vital Records, P.O. Box 68760,

or Attending Physician:

ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown
ted by Phy	Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.
Complete	PREU	MONIA

PUCUMONIA 25. Was case referred to medical examiner? 26. Place of Death (Ch

32. Registrar's Signat

24a. Was an autopsy performed? 1≰Yes 2☐No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
eck only one)	

1 ☐ Yes 2 🔁 N	0	поѕрна	1 Impatient	2 ER/Outpatient	3 🗌	DOA Other:	4 Nursing H	lome 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1 X Natural 2 ☐ Accident	5 Pending investigation	1	Date of Injury (Month, Day Ye	28b. Time of Injury	М	28c. Injury at Work?	2 🗆 No	28d. Describe how inju	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		Place of Injury - building, etc. (S	At home, farm, stree Specify)	t, fact	ory, office		28f. Location (Street a City or Town, Sta	and Number or Rural Route Numberte)

and manner stated.	1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.

and manner stated.		
29b. Signature and title of centiles	29c. License number	29d. Date signed (Month, Day, Year)
) ////// MD	00063580	03/22/2007

9/00/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital la (ous

Drive, Cheverly MD

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Deeth 3. Time of Death March Year Physician 0915 2007 Casey Huser /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 21 F Days Yrs Director MARCH 09,2007 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hyglene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Funeral Director Maryland Gaithersburg 1 ☐ Yes 2 ☑ No Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 796 Quince Orchard Blvd.- #101 20878 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2000No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None None 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Dean Huser Robyn Ann Gleason 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robyn Gleason-Huser, Mother 796 Quince Orchard Blvd., #101Gaithersburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 SBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 3/26/07 Silver Spring, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) 39 hours Due to (or es à consequence of): Examiner Examine 29 hours hydrops tetalis The law requires that the death certificate be executed ettending physician and for use es the bunal-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) resulting in death) Lest signed by the et id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 20 No 3 Probably 4 Unknown Kespiratry distress syndomie. SEPSIO, ascitio þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 X Yes 2 No 1 ☐ Yes 2 X No weeks gestanmed age funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) fillad in by 4 T Homicide ŏ To the Hospital o within 24 hours of To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) Winnbuly Lyblums

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) D50902 March 11, 2007 Iafolla, mo Medical Center Dove Rockyille, md 20850

State

Ruby airly Gleason

A Kimberly Tafo 31. Dete filed (Month, Day, Yeer) MAR 2.5



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Registrar

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			Registrar 1. Decedent's Name (First, Middle, L	(act)		Cei	unca	ie oi i	Jeaur	2	. Date of Death	g. No.		3. Time of Death
	Physici	an		_asi/							Month	Day	Year	
	/Medio		Sarah Henoch 4a. Facility Name (If not institution, g	ive street and num	ahor)		4h Cih	Town or	Location of		March	23, 20 4c. County		2:50 P M
	Examir	er					_ ′		Eccation of	Douth				
	Funeral	1	Montgomery Gen 5. Social Security Number 6.		7. Age (In yrs.	last birthday)	If Unde	lney er 1 Year	If Under 24		. Date of Birth		ontgo 9. Birthp	place (State or Foreign
	Director		505-05-4107	1□M 2\\ F	93	Yrs.	Months	Days	Hours	Min.	Month, Day,		Nebr	aska
	P		Usual Residence of Decedent								101 201	1713		
	irylar show	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f s	5		gomery	Si	lver S								
	vith the lor 2 be no	Ö	10e. Street and Number				10f. Zi	p Code			10	g. Citizen of	What Coul	ntry?
	death with the Maryland ms 23a or 28a-f show r must be notified at	Funeral Director	14400 Homecres		5 dent Ever in U	C 123	Man Dan	209		n2 (Cnasi	h, Van or No	USA 14 Bar	o - Americ	can Indian,
	item item ner r	ű.	11. Marital Status1 ☐ Never Married2 ☐ Married	Armed For	rces?	.5.	If Yes, sp	ecity Cuba	in, Mexican,	Puerto Ri	fy Yes or No- can, etc.)		ck, White,	
36	ırs af II', or Xami	þ	3 ₩idowed 4 Divorced	I 1 ☐ Yes If Yes, Giv Year or Da	ates:		1 ☐ Yes	2√ No	Specify:			Specii		White
ŏ	2 hou	ted	15. Decedent's	Education		16a. Dece	dent's Us	ual Occup	ation		1	6b. Kind of B		
215	hin 7. 9. an "n Medi	ble	(Specify only highest g Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT	ork done d use retired	during most o	or working				
21	d wit	Completed	12			Secr	etar	у ,						rernment
pu	be file	Be (17. Father's Name (First, Middle, La.	st)					18. Mother	s Name (/	First, Middle, M	laiden Surnai	ne)	
<u>ya</u>	Meni Meni arke	ဥ	Gershune Fellm								L1 Gube			
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship	(Type. Print)							Route Number,		, State, Zip	o Code)
o)	1 and Health		Gary Levy/Son 20a. Method of Disposition		20h F	1801 Place of Dispo			od Way	, Ulr	ney, MD	20832 Oc. Location	- City or To	own State
ŏ	ages It of h		1 Bunal 2 □ Cremation 3	☐Removal from S	State	cemetery, crei	matory or	other plac	i					
華	it. Partmel		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	**	Mt						5, 2007 s-Rinal			
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		21. Signature of Purietal Service L	Dane	000									ноте , MD 20904
B			23a. Part1. Enter the disease, onco shock, or heart failure. List en	omplications that ca	aused the deat								PLINE	Approximate interval Between
	Dhusisian		immediate Cause (Final	lly one cause on ea	ach line.	IDAY	0~.							Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	or as a conseq	uence of):	2111	4						
	Examiner			,	Mu		00	n 6	ailu	nl				2 dans
	-51	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	juence of):								2 de 25
	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events	с	110	1eur	200	500						C CAM P
,092	te be executed ysician and ne burial-transit		resulting in death) Last	Due to (or as a conseq	juence of):								
876	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	dical	•	d										
Box 68	ertific	/Me	IF FEMALE:	23c. if yes, out	nome of press	2004								
Bo	attendatter	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	irth 2 □ Feta ant at time of o	aldeath 3	⊒Ectopic □ Other (s	pregnancy					ate of deliv onth	ery Day Year
	the de	Physician/Medi	1 ☐ Yes 2 🛱 No 9 ☐ Unknown	9□Unkno	own	Jean 51	_ onlo	ресону)						
σ.	that independent	F.	Part II. Other significant conditions	s contributing to de	eath but not res	ulting in the u	nderlying	cause give	en in Part i.		23e. Did tob	acco use cor	tribute to t	the cause of death?
rds	quires n sign	d by	Swalle	- lensio	145F0	inch!	00				1 □ Ye	s 2 No	3 🗌 Pro	bably 4 □Unknown
Ö	w rec	lete	hyper	60550	7						24a. Was ar	24b.	Were auto	opsy findings available ompletion of cause of
æ	The la	Completed			<u>·</u>						autopsy perform	ned?	prior to co death? 1 ☐ Yes	
ta	an: Tiffical	Be C	25. Was case referred to medical						26. Place	of Death (Check only one		I L I es	20140
>	nysici lis ce direc	To B	examiner? 1 ∐ Yes 🏖 No	Hospital: 150	npatient 2] ER/Outpatier	nt 3 🗆 🖸	Oth	er: 4 Nur	sing Home	e 5 ☐ Reside	nce 6 □Ot	her (Speci	ify)
0	ng Ph fter th neral	L:u	27. Manner of Death	28a. Date of	of Injury th, Day Year)	28b. Time o Injury	ıf	28c. Injur Worl	y at k?	28	d. Describe ho	w injury occu	rred	
To the state of t							0							
Ξ̈́	or Att ter de lirect n by t	Ιij	3 ☐ Suicide 6 ☐ Could not determine		of injury - At h ng, etc. <i>(Speci</i>	ome, farm, sti fy)	reet, facto	ry, office		28	f. Location (Str City or Town		ber or Run	al Route Number,
	urs at		00-0-44	Dh laian Ta tha	heat of multiple	- deat	h 00011110	d at the tim		l place on		(2) 224		at a tand
	Hos 24 ho Fune etely f	Medical		Physician: To the caminer: On the ba										
	o the	Me	29b. Signature and title of certifier	and man		1/.	2	9c. Licens	e number		29	d. Date sign	ed (Month,	, Day, Year)
	3		> FTa	MO	tang			MI	206	3 99	9	3	1231	107
	2		30. Name and address of person wh			0 1	Print)			11/				1
			Atu Motame	edi, MD	18101	Prince	Phi1		r, 01r	ney,	MD 2083	2		
	Sta		31. Date filed (Month, Day, Year)	2007 32 8	egistrar's Sign	ature	Call !)						
	Regist	rar	A C & THIM	.001	Wes 1	5 /5/								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. O. T.

			1 - For State Registrar	ate of Maryland		tificate of L			erie 2 0 0 7	11177
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
	/Media	al		athan HARRIS	SON			March 2		10:15 A M
(Examir	er	4a. Facility Name (If not institution, give stree 1121 University Blvd			4b. City, Town, or Silver	Location of Death		4c. County of Deat	
3	Funeral Director		5. Social Security Number 6. Sex 107-22-5723	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 13,	9 Rin	hplace (State or Foreign unity) York
	land land		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside City Limits
	ath with the Marylan 23e or 28e-f ehow	tor	Maryland Montgomery	Si	lver	Spring				1 □ Yes 2 ☑ No
	or 28	Jire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	23e	rail	1121 University Blvd			209			United Sta	
9500-612	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or Iteme 23a or 28e-f ehow event, the Madical Examinar must be notified at	by Funeral Director	1 X Never Married 2 Married 1	Vas Decedent Ever in U.S med Forces? ∑Yes 2 ⊡ No Yes, Give fear or Dates: Korea	lf 1	Vas Decedent of Hi Yes, specify Cubar ☐ Yes 2X No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: wh	
ה ה	72 ho	eted	15. Decedent's Educatio (Specify only highest grade cor	n (nated)	16a. Deced	ent's Usual Occupa	ation	ring 1	6b. Kind of Business/	Industry
	within 72 ene. than "nai	Completed		college (1-4or 5+)	Cler	kind of work done a OO NOT use retired,)		Securities	
N D	e filed wit al Hygiene other the vent, the	e Co	17. Father's Name (First, Middle, Last)		Crer	κ.	18. Mother's Nam	e (First, Middle, M	Exchange C	Ommission
yiand	Aental rked o	To Be	Sol Harrison				Esther			
, Mary	and 2 sho alth and N 127 te ma or treuma		19a. Informant's Name/Relationship (Type. F Harold Norken, Nephe		19b. Mailin 14637	Sandy Ri	and Number or Rur .dge Road	al Route Number, , Silver	City or Town, State, Z Spring, M	Tip Code) D 20905
Baitimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: if item 27 is marked any injury or other treumatic signes.		20a. Method of Disposition i ↑ Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)	ral from State COI	netery, crem	sition (Name of latory or other place on Cemete	9)		Oc. Location - City or Adelphi, M	
Dail	permit. Departimont important injury		21. Signature of Funeral Service Licensee			Name and Addres rchinsky 4 Carroll				20012
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car	ns that caused the death. use on each line.	Do not ente	r the mode of dying	, such as cardiac	or respiratory arre	st,	Approximate Interval Between
<u>}</u>	Physician		Immediate Cause (Final disease or condition resulting in dealh)	Myocardial I	nfarct	ion				Onset and Death
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	and transli	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Diabetes Mel						
Š,	rificate be executed ag physicien and as the burial-transit	aiEy	resulting in death) Last	Due to (or as a conseque	ince of):					
58/6U,	tificate ig phys as the	edicai	d							
C. BOX	w requires that the death cert been signed by the attending should be detached for use a	Physician/M	in the past 12 months?	yes, outcome of pregnand □Live birth 2 □ Fetal d □Pregnant at time of dea □ Unknown	leath 3□	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
	that the ed by detac		Part II. Other significant conditions contribu	ting to death but not result	ing in the un	derlying cause give	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
coras,	equires sen sign ould be	ted by								bably 4 Unknown
nec	To the Hospital or Attending Physician: The law requires that within 24 hours after dear after days to the Funerel Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detailed.	Completed	,					24a. Was an autopsy perform 1 Yes 2	prior to o death?	topsy findings available completion of cause of
VII	sician certifi rector	Be	25. Was case referred to medical examiner?	al:		3□ DOA Othe		h <i>Check onli</i> one		
5	g Physer this eral di	일	27. Manner of Death 28	1 Unpatient 2 UE	R/Outpatient 8b. Time of	3 DOA 28c. Injury Work	4 Nuising no	me 5 Resider 28d. Describe how	nce 6 Other (Spec winjury occurred	ufy)
202	tending eath. for: Aft the fun	catio	2 Accident investigation		Injury	M 1 7	? ′es 2 □ No			
2	ital or At irs after d ref Direct led in by	Certification;	4 Homicide determined 28	e. Place of Injury - At hom building, elc. (Specify)	ie, larm, stre	et, factory, office	1	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	he Hosp in 24 hou he Fune pletely fil	Medical	(Check only 2 Medical Examiner;	i: To the best of my knowl On the basis of examinatio nd manner stated.	edge, death in and/or invi	occurred at the fim- estigation, in my op	e, date and place, inion, death occuri	and due to the cau red at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	with To t	Σ	29b. Signature and title of certifier	611		29c. License			d. Date signed (Month	
•	10+1		Marie	4/14	ar	9	D 05937	M	March 23, 2	2007
			30. Name and address of person who comple Robert Kramer, M.D.,				Sufta 21/) C41	· Carina 1	D 20902
	Sta		31. Date filed (Month, Day, Year)	32 Pegistrar's Signatur			Durce 21	o, STIVEL	. Spring, r	20302
	Registr	ar	MAR 2 6 2007	Paragraph O	h Zan					

State of Maryland / Department of Health and Mental Hygiene

			1 - For State O Registrar	Marylan		rtificate of I	ieaiin and iv Death	, ,	ene g.No.つ ∩ ∩	7 11:70		
q	Physicia	an.	1. Decedent's Name (First, Middle, Last)		ROY H	UTZEL		2. Date of Death Month		3. Time of Death		
7	/Medic		-HAVARD- =EER-O			HUTZE	. 74	Month 03	20 07			
	Examin	er	4a. Facility Name (If not institution, give street and nur.			Location of Death		4c. County of De	eath			
		2	WMHS-BRADDOCK CAMPUS 5. Social Security Number 6. Sex	7. Age (In yrs.	last hirthday)	CUMBERLA If Under 1 Year	AND If Under 24 Hrs.	8. Date of Birth	ALLEGAN	√Y Birthplace <i>(State or Foreign</i>		
2	Funeral Director		215-16-4580 Usual Residence of Decedent		4 Yrs.	Months Days	Hours Min.	June 25	, 1922 Ma	Country) aryland		
	yland now at	Ы	10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits		
	a-f sh ified	ctor	MD Garrett	Gran	ntsvil	le				1 □Yes 2 No		
	th the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?		
	23a ust b		5791 National Pike			21536		τ	JSA			
	tems er m	Funeral	Armed Fo		S. 13. \	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Al Black, W	merican Indian, /hite, etc.		
36	s afte	by F	1 ☐ Never Married 2 🛣 Married 1 ☐ Yes, Giv 3 ☐ Widowed 4 ☐ Divorced Year or Div	2□No e ates: WW2		1 □ Yes 2 K No	Specify:		Specify:	71		
21215-0036	tural		15. Decedent's Education	iles. YYYYZ	16a. Deced	dent's Usual Occup	ation	- 1	6b. Kind of Busines	Nhite ss/Industry		
212	nin 72 In "na Medik	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1	-4or 5+)	(Give life. L	kind of work done o DO NOT use retired	during most of worki i)	ing		,		
27	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	Completed	7	-101 01)	Fore	man		(Construct	ion		
g	be filed Ital Hygi od other event, t	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M	aiden Surname)			
<u>X</u>	should be and Mental s marked o umatic eve	P_	Frank Hutzel				Ida Durs					
Maryland	2 sho		19a. Informant's Name/Relationship (Type. Print)				and Number or Rura		_	e, Zip Code)		
	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		Gladys E. Hutzel/Wife	205 0		National sition (Name of	Pike, Gra			536		
ŏ	Pages nent of hint: If ite		20a, Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from 3	State c	emetery, crer	natory or other plac	e)	-	0c. Location - City			
Baltimore,	it. Pa intmer intant injury		4 □ Donation 5 □ Other (Specify) 21. Signatore of Funeral Service Licensee	Grai		Le Cemete . Name and Addres	ry March		Grantsv neral Hom			
ga	permit. Pages Department of Important: If it any injury or once.		Lau Jaman)			275, Grant			-		
			23a. Part1. Enter the disease, r complications that c shock, or hear failure. List only one cause on e	aused the death ach line.	n. Do not ent	er the mode of dyin	g, such as cardiac o	or respiratory arres	st,	Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	IMAR	y Fo	ULMOI	VARY 1	TYPER.	TENTIO	Onset and Death M X E A R S		
	/Medical Examiner		resulting in death) Due to (or as a consequ	uence of):		Marie Comment					
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o n	ath ce ttendi or use	sician/M	23b. Was decedent pregnant	irth 2□Fetal	Ideath 3□	Ectopic pregnancy	,		23d. Date of o			
	that the death cer ed by the attendin detached for use	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	ant at time of down	eath 5□	Other (specify)			Month	Day Year		
7.	that that the sed by detacl	Phy	Part II. Other significant conditions contributing to de	ath but not resu	ulting in the ur	nderlying cause give	en in Part I	23e. Did toba	acco use contribute	e to the cause of death?		
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Ĕ	sician; The law certificate has b rector, page 2 sl	Completed	MINIL FISKIL	AIIOI	Y			autopsy perform	prior t	autopsy findings available to completion of cause of 1?		
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Sion	Attending P or death. rector: After by the funer	atio	2 Accident investigation	ii, Day Tear)	Injury		Yes 2 □ No					
<u> </u>	er de lrecto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place buildin	of injury - At ho	me, farm, str	eet, factory, office		28f. Location (Stre	eet and Number or State)	Rural Route Number,		
2	ital o rrs aft ral DI led ir	ë							·			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the base and mann	best of my kno asis of examina er stated.	wledge, death tion and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the car red at the time, da	use(s) and manner te and place, and o	as stated. due to the cause(s)		
	To th withir To th comp	Me	29b. Signature and title of certifier	1		29c. License	e number	29	d. Date signed (Mo	onth, Day, Year)		
			Sm Ki	ann.	2-13-	Do	0540	24	3/21/	67		
		}	30. Name and address of person who completed caus	e of death (Item	23a) (Type,	Print)	1			0 0		
			DR. Shir Khanna	991E	Nat	monal t	twy. L	aval	6 MD	71207		
E	Sta Registr		31. Date filed (Month, Pay, Year) 32. PMAR 2 3 2007	gistrar's Signa	ture	Card .	1					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3/21/2007 **Physician** John F. Heimbuch 1:30 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Crofton Convalescent Crofton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 NJ 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Months Days Hours Min 94 5/19/1912 141-09-9489 Director Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 ☐ Yes 🏋 No Director MD Anne Arundel Harwood 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 195 Harwood Rd. 20776 USA 'natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No White Specify þ 3 ☐ Widowed 4 € Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Draftsman/Designer Aerospace 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edmond Heimbuch Appolonia Merkel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Douglas Heimbuch Son 195 Harwood Rd. Harwood, MD 20776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3/24/2007 Owensville, MD 4 □ Danation 5 □ Other (Specify) Our Lady of Sorrows Aervice Licensee 21. Signal ure of Funeral 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lure. List only one cause on each line. i. Enter the d Atheroschotic CondioVascular Distarc **Physician** /Medical Due to (or as a consequence of) Examiner brillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-trans Due to (se as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 1 Yes 2 No 2 TER/Outpatient 3∏ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 5 To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 ☐ Pending 1 ∏Yes 2 ∏No investigation 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D20108 Ich arona 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 14300GALLANT FOXLN#222 BOWIE MD 20715 KAKESH AROR 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 2 3 2007

ORIGINAL

24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes No 25. Was case referred to medical examiner? 1 Yes No 26. Place of Death (Check only one) 27. Manner of Death 1 Yes No 28. Deate of Death (Check only one) 28. Place of Death (Check only one)			For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H			giene (007	11180
Director Season Season From Season Sea				st)				2. Date of De	ath	Vac-	3. Time of Death
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Social Security Number 15 15 15 15 15 15 15 1	Exam		Union Hospital of	Cacil Co	untv	Fileton			Co	cil	
Dec. 28, 1951 Maryland Top County To	Funeral					If Under 1 Year		s. 8. Date of Bir	th	9. Birth	place (State or Foreign
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Susan P. Hines Wife 190	h wit		757 Appleton Road			21921			Unite	d Stat	ec
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Susan P. Hines Wife 190	od within 72 hours after gjene. er than "natural", or ite i tre Medic: Esterilise	Ē	1 ☐ Never Married 2 ☑ Married	1 ☑ Yes 2 🗆 I	NO A semse			ano Rican, etc.)			etc.
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23d Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Bisween control and part of the past 12 mondate Cause (Chinat Bismediate Cause (Chinat Bismedi	fenta fenta ked ic e		William Hines				Mary Ri	uth Hendi	rick		
23d. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Blawlers above, or heart failure. List only one cause on each line. Immediate Cause (Final Proposed of Cause (Final Pro	shou od N ma	_		Type, Print)	19b. Maili	ng Address (Street				own, State, Zip	Code)
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233. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introducing a clause (Final Date) (or as a consequence of): Approximate interval Between Short or heart failure. List only one cause on each line.	rtme rtan rian				North Ea	st Method	ist 27	,_20071	Vorth	East,	Maryland
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1 Solution 1 Solution 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, streel, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date filed (Month, Day, Year) 29d. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32 Registrar's Signature 31. Date filed (Month, Day, Year) 33 Registrar's Signature 34 Accident 3 State 35 Continued 3 State 36 Could not be determined 29d. Date signed (Month, Day, Year) 36 Could not be determined 29d. Date signed (Month, Day, Year) 29d. Date signed (I or Attending Phy. after death. Director: After this	H- 1									у/
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Company one) 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 33 Registrar's Signature MAR 2 7 2007	after Dire	erti	4 Homicide	building, et	c. (Specify)	,,,					
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MD D0063720 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Viban'i Avan 118 North Breet Ste 3B Eledon MD 29a State Begistrar MAR 2 7 2007 MAR 2 7 2007	o the ithin o the	Me	A-			29c. License	number		29d. Date s	igned (Month.	Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vitan i Avam 118 North 87 ret Ste 3 B Elizan MD 29a State Registrar MAR 2 7 2007	F 2 F 2		1//~	MAG	`	n	0/2	700	07	20/2	7
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			For State Registrar	State of Mar	yland /		artment of H			giene (07	1 8 1
Phy	sicia	n	Decedent's Name (First, Middle, Last, CEODGE LITT CON						2. Date of De Month 03	ath Day 20	Year	3. Time of Death
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			GLADYS SPELLMAN N		ITER		Chever1			Princ	e Geor	
Fune Direct	_		5. Social Security Number 6. Sec. 577–20–0976 Usual Residence of Decedent		in yrs. last b	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		y, Year)	9. Birthp Coun Darli	lace (State or Foreign try) ngton,SC
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ath with the Marylan 123a or 28a-f show		Funeral Director	10e. Street and Number				10f. Zip Code	1602		10g. Citizen o	of What Coun	itry?
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UUSO hours after death with the Maryland tural, or fleme 23a or 28a-f show all Example of the conditions		2	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2表 No If Yes, Give Year or Dates:		'	f Yes, specify Cuba I ☐ Yes 2€3;No	Specify:	rto Rican, etc.)	В	slack, White, cify: B1ac	etc.
Z15-UU36 thin 72 hours at 6. on "neturat", or		eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	16	(Give	lent's Usual Occup	during most of wo	orkina	16b. Kind of	Business/Ind	dustry
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Heal Heal		ł	Bernard R. Tabron/ 20a. Method of Disposition				ottsiite sition (Name of natory or other place		Date		n - City or To	wn, State
Pages nent of nnt: If It			1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	cemet Lincol	ery, cren Ln M	em. Cemet	ery 03-	26-2007	Suitlar	nd Md.	
Baltimore, permit. Pages 1 ar Department of Heal Important: If Item any Injury or othe	Suc		21. Signature of Funeral Service Licens Mary Hodiama		14	22	. Name and Addre	ss of Facility				1. 20746
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9			30. Name and address of person who co Ravinder K. Rust	agi,MD 61	32 La:	ndov	er Road	Chever1	y, Maryl	and 20°	785	
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			For State Reglstrar	State of I	Marylar		artment o			∕lental Hy	giene Reg. No.	0 0 0	7 11100
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No.	/Medio		4a. Facility Name (If not institution				4b. City, Tow	n, or Loca	tion of Death	MARCH	24 4c.	2007 County of De	10:40 p M
			Paint Branch Nu				Ade1p					rince G	
	Funeral Director		5. Social Security Number 578-42-3957 Usual Residence of Decedent	6. Sex 7. 1 ☐ M 2 🔀 F	Age (In yrs. 84	last birthday) Yrs.	If Under 1 Y Months Da	ear If Ui ays Ho	nder 24 Hrs. urs Min.	8. Date of Bir (Month, Da June 1	av. Year)	1 (rthplace (State or Foreign Country) irginia
	Maryland -f show ijed at	tor	10a. State 10b. County VA Arlin	ngton		ty, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 📉 No
	th the or 28a e notif	Director	10e. Street and Number				10f. Zip Co	de			10g. Citi	zen of What C	country?
	ath wi	ral	120 S. Barton S					2204				USA	Total Andrea
36	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force ed 1 Tyes 2 If Yes, Give Year or Date	s? XINo		Was Decedent If Yes, specify 1 □ Yes 2 🔀			pecify Yes or No Rican, etc.))- 	14. Race - Am Black, Wh Specify:	
Baltimore, Maryland 21215-0036	within 72 hou ene. than "natura the Medical E	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education if grade completed) College (1-4)	or 5+)	16a. Deced (Give life.	dent's Usual O kind of work d DO NOT use re	ocupation one during etired)	most of wor	king	16b. Ki	nd of Busines	
2	e filed withir al Hygiene. other than vent, the Me	Com	12th			Supe	ervisor				GPO		
yland	2 should be fil and Mental H is marked oth aumatic even	To Be	17. Father's Name (First, Middle, Otto Boswell					E	Eloise	e (First, Middle Wilson			
Mar			19a. Informant's Name/Relations							ral Route Numb ington,			
ē,	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		Sharon J. Turne 20a. Method of Disposition	er/Daugnter			7th St sition (Name of matory or other		wasii	Date		cation - City c	
ШO	0 0		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S _i		ite		e t Ceme		3-3	0-2007	Was	shingto	on, D.C.
Balt	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service	Licensee Washin O	C		Marshal 4217 9t			l Home, Washi		n, D.C.	20011
	Physician		23a. Part. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition			th. Do not ent		dying, suc	ch as cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
1	/Medical		resulting in death)	a	as a consec								
	Examiner	<u>.</u>	Sequentially list conditions,		stive		Failur	e					
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Diabe		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
Ö,	e exec ian an	Exa	resulting in death) Last	`	as a consec							· · ·	
8760,	icate be executed physician and s the burial-transit	dical		d. Alzhe	imers	Demen	tia						
.O. Box 6	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ဩtNo 9 □ Unknown	23c. If yes, outco 1 □Live birtl 4 □ Pregnan 9 □ Unknow	n 2 □ Feta tat time of a	al death 3 [⊒Ectopic pregn ☐ Other (specil				:	23d. Date of d Month	elivery Day Year
Δ.	uires that signed by d be deta	by	Part II. Other significant condition	ons contributing to deat	h but not res	sulting in the u	nderlying caus	e given in f	Part I.				to the cause of death? Probably 4 ☑ Unknown
Records,	The law requires that ate has been signed b page 2 should be deta	Completed									psy ormed?	prior to death?	autopsy findings available completion of cause of
ita	(D) L-L	Be Co	25. Was case referred to medical					26. 1	Place of Dea	1 Yes th (Check only	2 ∑ No one)	1 □ Y∈	es 2 No
<u>۲</u> ۷	> .0 D	TO E	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inp		ER/Outpatier			∑ Nursing H	ome 5□Res			necify)
ouc	ing After		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig		njury Day Year)	28b. Time o Injury		Injury at Work? 1 □ Yes	2□No	28d. Describe	how injur	y occurred	
Division or Vital	or Attending after death. Director: Aftel I in by the fune	Certification:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determ	ot be 28e. Place of	injury - At h , etc. <i>(Speci</i>	ome, farm, str fy)	reet, factory, of		20110	28f. Location (City or To	Street an wn, State	nd Number or I)	Rural Route Number,
	To the Hospital or Attendiwithin 24 hours after death. To the Funeral Director; A completely filled in by the fu	ledical C		g Physician: To the be Examiner: On the basi and manner	s of examin								
	To the within 2 To the comple	Me	29b. Signature and title of certifier				29c. Li	cense num	ber		29d. Dat	te signed (Moi	nth, Day, Year)
	1 20		Maomi	Hedish	and	- 00c) (T		7838				3-26-20	007
1	-(4)		30. Name and address of person Naomi Ihedioha	, M.D. 620)1 Gre	enbelt	1.	Suite	U-7	College	Par	k, Md.	20740
	Sta Regist		31. Date filed (Month, Day (Mar)	32. Reg	istrar's Sign	the state of							

		FOI	epartment of Health and Certificate of Death	Mental Hygiene
Physici		Decedent's Name (First, Middle, Last) THOMAS F. JOHNSOI	N.	2. Date of Death Month Day Year MARCH 21, 2007 8:45 P
/Medio Examir		4a. Facility Name (If not institution, give street and number) FAIRLAND NURSING HOME	4b. City, Town, or Location of Deat SILVER SPRI	th 4c. County of Death
Funeral Director		5. Social Security Number 014-18-1748 014-18-1748 014-18-1748 05. Sex 1	hday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	
the Maryland 28a-f show otified at	Director	10a. State 10b. County 10c. City, Town MD MONTGOMERY 10e. Street and Number	SILVER SPRING 10f. Zip Code	10d. Inside City Limit 1 XiYes 2 □ N 10g. Citizen of What Country?
3a or		15107 INTERLACHEN DR. #324	20906	U.S.A.
72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 M Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 🌠 No Specify:	Specify Yes or No- 14. Race - American Indian,
l within piene. r than "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+	Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) PROFESSOR	orking 16b. Kind of Business/Industry UNIVERSITY
ould be filed Mental Hygi Iarked other Iatic event, tl	To Be C	17. Father's Name (First, Middle, Last) FAIRFAX JOHNSON		me (First, Middle, Maiden Surname) THERINE HAMLET
2 should and Men is marke aumatic	F			tural Route Number, City or Town, State, Zip Code)
s 1 and of Health item 27 other tr		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20b. Place of cemeter.	Disposition (Name of y, crematory or other place)	#324, SILVER SPRING, MD. 2090 Date 20c. Location - City or Town, State 22–2007 RIVERDALE, MD.
permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Ligensee M00091	22. Name and Address of Facility CHAMBERS FUNERAL H 5801 CLEVELAND AVE	OME & CREMATORIUM, P.A.
/Medical Examiner bhysician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Chause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or consequence o	rf):	
aath certii attending for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
quires that the de n signed by the a lid be detached	출	Part II. Other significant conditions contributing to death but not resulting in DEMENTIA	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🌠 No 3 ☐ Probably 4 ☐ Unknov
The law ate has b page 2 sl	Completed	CORONARY ARTERY DISEASE		24a. Was an autopsy performed? 1 ☐ Yes 2 🛣 No 24b. Were autopsy findings availat prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
ding Phys	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No	patient 3 DOA Other: 4 Nursing I	hath (Check only one) Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred
i Diffe	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, far building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital within 24 hours a To the Funeral completely filled	Medical	one) and manner stated.	d/or investigation, in my opinion, death occ	curred at the time, date and place, and due to the cause(s)
2 1 1 2 1 5 1 5 1 5 1 5 1 5 1 5 1 5 1 5	Σ	29b. Signature and title of certifier	29c. License number D58962	29d. Date signed (Month, Day, Year) MARCH 22, 2007
Sta	ate	30. Name and address of person who completed cause of death (Item 23a) (** SHASHANK G. PATEL, M.D. 2309 31. Date filed (Month, Day, Year) MAR 2 6 2007	Type, Print) SHOREFIELD RD., WHE	

Physician /Medical Examiner law requires that the death certificate be executed

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: ID

	Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Due to (or as a conseq		ı			Onset and Death
ical Examiner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	·	rotic Card uence d). mia	liovascular Di	isaase		
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of d 9 □ Unknown	al death 3 □Ectopi	c pregnancy (specify)		23d. Date of de Month	elivery Day Year
Completed by Pt	Part II. Other significant conditions co		ulting in the underlyir			res 2 1 No 3 F an 24b. Were a sy prior to death?	to the cause of death? Probably 4 Unknown autopsy findings available completion of cause of us 2 No
o Be	25. Was case referred to medical examiner? 1 ★ Yes 2 → No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3		ath <i>(Check only or</i>	ne) ence 6	ecifv)
ation: T	27. Manner of Death ★★★★★★★★★★★★★★★★★★★★★★★★★★★★★★★★★★★	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occurred	
Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Special	ome, farm, street, fac fy)	tory, office	28f. Location (S City or Tow	treet and Number or F in, State)	Rural Route Number,
edical (sician: To the best of my known iner: On the basis of examination and manner stated.					
Me	29b. Signature and title of certifier Dalen B. The	Chich mp		29c, License number D28426	2	29d. Date signed <i>(Mor</i> March 2	nth, Day, Year)

State

Registrar

31. Date filed (Month, Day, Year)

MAR 2 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Galen Hallick, M.D. 10215 Fernwood Road, #100, Bethesda, MD 20817

Registrar's Signature

WH-10+1

State Registr<u>a</u>r Date filed (MorMAR 28 200)

32. Pogistrar's Signature

Sperke

agers Town

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 21, Day 2007 Year **Physician** ESTHER T. LEVIN 3:45 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Nursing Home Potomac Montgomery 5. Social Security Number if Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 2, 1917 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 161-01-9007 89 Oct. Director PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the M. Ical Examiner must be notified at 1√Yes 2□No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 4924 Sentinel Drive, # 204 20816 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No White Specify Specify: ò 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 Years College (1-4or 5+) Bookkeeper Food permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any linky or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hyman Cohen Rose Gindes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Hoffman - Daughter 4924 Sentinel Drive, # 204, Bethesda, Maryland 20816 Baltimore, 20b. Place of Disposition (Name of Menoral Charles Funeral Charles Funeral Charles 20a. Method of Disposition Date 20c. Location - City or Town, State Southwest Ranches, Florida 1 → Burial 2 □ Cremation 3 N Removal from State Mar. 25, 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DAYS Immediate Cause (Final disease or condition resulting in death) Asperation Pneumonia **Physician** /Medical Due to (or as a consequence of): Examiner Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Cerebra Vascular Accident the death certificate be executed and burial-tra Due to (or as a consequence of) attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Atherosclerosis Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Diabetes Mellitus Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performed? certificate 2 No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 1 ⊞ Naturai 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide TC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D31319 March 22, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) MAR 2 6 2007



			State of Maryland	•		lental Hygie	ne	
			Registrar	Certificate of	Death	Reg.	No. 2007	111187
100	Physici /Medic		1. Decedent's Name (First, Middle, Last) Eugene B. Laskin			2. Date of Death MonthMarcl	Ƙ ^{ay} 22 , 2 007	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	Location of Death		4c. County of Death	
			3210 N. Leisure World Blvd #602 5. Social Security Number 6. Sex 7. Age (In yrs. las		Spring If Under 24 Hrs.	8. Date of Birth	Montgomer	y place (State or Foreign
	Funeral Director		219-01-1879 1XIM 2 F 89	Yrs. Months Days	Hours Min.	(Month, Day, Ye	ear) Cou	ntry) MD
	The state of the second		Usual Residence of Decedent			11/20/19	17	НД
	how at			Town or Location				10d. Inside City Limits
	e Ma 3a-f s	cto	MD Montgomery Silv	er Spring				1 XYes 2 No
	th with the 23a or 24 st be no	Funeral Director	10e. Street and Number 3210 N. Leisure World Blvd #602	10f. Zip Code 20906			. Citizen of What Cou nited Stat	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give WW II	If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify:	
21215-0036	hin 72 hou e. an "natura Medical E	Completed b		16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of work		b. Kind of Business/li	ndustry
	ed wit	PO P		Engineer			rivate	
Maryland	should be file and Mental Hy s marked oth umatic event	To Be (17. Father's Name (First, Middle, Last) Meyer Laskin		18. Mother's Name Ida Shum	e (First, Middle, Mai an	iden Surname)	
ary	shou and M s mar		19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street				
	and and and m 27 i		Mary Laskin - Wife	3210 N. Leist				Spring MD
Baltimore,	Pages 1 lent of H nt: If ite ry or oti		Cen	ce of Disposition (Name of netery, crematory or other place ean Memorial Garde	re) !		c. Location - City or T $1{ m nev}$. MD	own, State
Balti	permit. Departm Importa any Inju		21. Signature of a ral Schuice Licensee	22. Name and Addre	ss of Facility Edwa	ard Sagel	Funeral I	
			23a. Part . Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not enter the mode of dyir				Approximate Interval Between
	Physician	N	Immediate Cause (Final disease or condition Arterios	clerotic Cardi	io Vascul	ar Diseas	e	Onset and Death Years
1	/Medical Examiner		resulting in death) Due to (or as a conseque					
1	sit sd	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Processes in the cause)	ence of):				
Ć,	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a conseque	ence of):				
68760,	ate be hysicla the bur	dical	d					<u> </u>
		/Мес	IF FEMALE: 23c. If yes, outcome pf pregnance	cv			23d. Date of deliv	ven.
.O. Box	that the death certified by the attending detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	leath 3 ☐Ectopic pregnancy			Month	Day Year
Ω.	requires that the een signed by th nould be detache	by Ph	Part II. Other significant conditions contributing to death but not resulti	ing in the underlying cause giv	en in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
ords	w require been sig should b	ed b				1 ☐ Yes	2 No 3 □ Pro	bably 4 Unknown
Records,	e law has b je 2 st	Completed				24a. Was an autopsy performed 1 Yes 2 ☑	prior to c d? death?	opsy findings available ompletion of cause of
ita	10 0	BeC	25. Was case referred to medical		26. Place of Deat	1 Yes 2 Land 1	9440 ILlites	241 140
>	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 XNo Hospital: 1 ☐ Inpatient 2 ☐ Ef	R/Outpatient 3 DOA Oth	er: 4 🗆 Nursing Ho	ome 5 AResidenc	ce 6 □Other (Spec	ify)
o uo	Te Te	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28b. Time of lnjury M 28c. lnjur Wor	yat k? Yes 2 ∐ No	28d. Describe how	injury occurred	
Division or Vital	al or Atters after dea	Certification:	G□ Could not be	ne, farm, street, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. I To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowl 2 Medical Examiner: On the basis of examination and manner stated.					
	Withir Comp	Me	29b. Signature and title of certifier	29c. Licens MD08			Date signed (Month arch 22, 2	
	•		30. Name and ddress of p rson who completed cause of death (Item 2 Benjamin Avrunin MD 18111 Princ		e Olney M	D 20832		
	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 6 2007 32 egistrar's Signatu	se Species				

				State of Ma		epartment of		•	_	
			1 - State Registrar			Certificate o			Reg. No.	11188
5.	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	ath Day Year	3. Time of Death 11:30am
Ping.	/Medic Examir	al	Catherine Livin 4a. Facility Name (If not institution, give			4b. City. Town	, or Location of De	Mar.	22, 2007 4c. County of Dea	
	Lxamii		302 12th Avenue				ooklyn Pa		Anne Ar	undel
1	Funeral Director	-Con-	5. Social Security Number 6. Security Number 11	ex 7. Age □M 2⊠F	(In yrs. last birthe	Months Day		in. (Month, Da	h 9. Bir y, Year) C	thplace (State or Foreign ountry)
	D		Usual Residence of Decedent					reb.	12, 1921	MD
	Aarylar f ehow	ō	10a. State 10b. County MD Anne Ar		10c. City, Town	yn Park				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28e-i	irect	10e. Street and Number	ander	3100K1	10f. Zip Code	9		10g. Citizen of What C	ountry?
	ath wit	raiD	302 12th Avenue				21225		USA	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "nature!", or Iteme 23a or 28e-f show amy njury or other treumatic event, the Madical Example must be mailled at Ange.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☆ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	ver in U.S.	13. Was Decedent of If Yes, specify Control of It Yes 250 N		(Specify Yes or No- erto Rican, etc.)		
2	72 ho	Completed	15. Decedent's Ed (Specify only highest gra-	ucation de completed)	16a. D	ecedent's Usual Occ Give kind of work dor	supation ne during most of v	vorking	16b. Kind of Business	/Industry
72	within iene. rthen	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	ife. DO NOT use reti Homemak	-		Home	2
Maryland 21215-0036	uld be filed Mental Hyg irked other itic event,	To Be C	17. Father's Name (First, Middle, Last) Henry Nagel		,		18. Mother's N	lame (First, Middle, Schnappi)		
Man	12 sho		19a. Informant's Name/Relationship (7 Catherine Ludwit						er, City or Town, State, rk, MD 2122	
	Healt Healt tem 2		20a. Method of Disposition	ZNE/ NIECE	20b. Place of D	isposition (Name of		Date	20c. Location - City or	
ê E	Pages nent of ant: if i		1 ⊠Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			even Mem.	Park	rch 24, 2007	Glen Bu	rnie, MD
Baltimore,	permit. Departr Importe any nji		21. Signatu Fundral Service Licen	Alla		22. Name and Add Barranco 495 Gov.	tress of Facility & Sons,	P.A. Sev	verna Park verna Park,	Funeral Home MD 21146
*			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of tmmediate Cause (Final	plications that caused to one cause on each line	he death. Do no a.	t enter the mode of d	lying, such as card			Approximate Interval Between Onset and Death
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o Î	te be executed ysicien and e burial-transit		that initiated events resulting in death) Last	Due to (or as a	consequence of		VE JEHO			(Jean
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Box 6	leath certificate t attending physicaters and the terms are the terms.	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o					23d. Date of de	livery
P.O. B	that the death ed by the atte detached for	Physician/Med	in the past 12 months? 1 ☐ Yes ♣ No 9 ☐ Unknown	1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown		3 □Ectopic pregnal 5 □ Other (specify)			Month	Day Year
	w requires that been signed should be det	Ď	Part II. Dther significant conditions or	ontributing to death but	not resulting in the	ne underlying cause	given in Part I.		obacco use contribute t res 2 No 3 P	o the cause of death?
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Vita	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		10)ther	eath (Check only o		
ō	ding Phys h. After this funeral di	on: To	27. Manner of Death	1 ☐ Inpatien 28a. Date of Injury (Month, Day)	t 2 ☐ ER/Outp 28b. Tin Yea <i>r</i>) Inju	ne of 28c. In			dence 6 Other (Spenow injury occurred	ecify)
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N N	Hospitel or Attending 24 hours after death. Funerel Director: After tely filled in by the fune.	Certification;	4 Homicide determined	building, etc.	y - At home, tarm (Specify)	i, street, factory, offic	÷ e	281. Location (S City or Tow	Street and Number or R vn. State)	ural Route Number,
	To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by	Medical (29a. Certifier (Check only one) 1 Certifying Phyone) 2 Medical Exem	ysicien: To the best of niner: On the basis of a and manner state	examination and/	death occurred at the or investigation, in m	time, date and pla y opinion, death of	ice, and due to the occurred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
1	To t. To tl	Σ	29b. Signature and title of certifier		2		nse number		29d. Date signed (Mon	
7			30. Name and address of person who o	completed cause of de	ath (Item 23a) /T-	(pe Print)	185	of	0)-22	27
	10		Charles J. Wu	M.D. 1	,005.0	rasa Hu	og Ste.1	06 Glen	Burnie, M	5 21061
	Sta Registr		31. Date filed (Month, Day, Year)	2007 32. Registrar	's Signature	book	٧			

State of Maryland / Department of Health and Mental Hygiene 1- For Amend #8 Per FH C867 5/24/07 Jh Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** ΡM 2007 7:45 1, April SAMUEL HARRY MACRUM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Frederick Memorial Hospital 8. Date of Birth (Month Day, Yea May 14, 2 f Under 1 Year If Under 24 Hrs. 1925 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Pennsylvania 81 198-18-6818 Director ks Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits r 28a-f show notified at 10a. State 10b. County Frederick 1 ☐ Yes 2 No Frederick Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or 21702 U.S.A. 8701 Opossumtown Pike nit. Pages 1 and 2 should be filed within 72 hours after death warment of Health and Mental Hygiene.
ortant: If item 27 is marked other than "natural", or items 23a Injury or other traumatic event, the Medical Examiner must. Funeral 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 Nes 2 No 1943 to Year or Dates: 10/6 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify.White þ 3 ☐ Widowed 4 ☐ Divorced 1946 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Enginerring d 2 should be filed w. th and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna B. Cramer Samuel H. Macrum, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James H. Macrum/Son 8665 Opossumtown Pike, Frederick, Maryland 21702 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Mt. concern crematory or other place) April 5, 2007 Frederick, MD 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department or Important: If any Injury or 4 Donation 5 Other (Specify) 21. Sign of Faheral Service Licens MQ0021 22. Narrender and Basford Funeral Home 106 East Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyling, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BILATERAL PNEUMONIA Physician 1744 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): be executed signed by the attending physician and be detached for use as the burial-tran Box 68760,% Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∏ Yes Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Tinpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours a er dear To the Funeral Director completely filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 4-2-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 4 Cul 32 Registrar's Signature Ronald E. Miller 4 Culwell Drive, Mt. Airy, MD 21771 31. Date filed (Moeth, Day, Year) State Registrar

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p-			Registrar 1. Decedent's Name (First, Middle, La	ist)		Cei	lilicale	OIL	Jealii		2. Date of De	Reg. No.		3. Time o	I J U
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	Examir		4a. Facility Name (If not institution, give	e street and numbe	r)		4b. City, 7	Town, or	Location of	of Death		4c.	County of De	ath	
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	(2)		1/1/8301-						-			mar	CII 27	, 2007	
)_	(2)		30. Name and address of person who MICHAEL SIDARO					מא	# *	1 / 1	FT. WA	лспт	ווכיייטעי	MD	20744
	Sta	te	31. Date filed (Month, Day Year)		strar's Signa		5	110	- μ	. 0 1	- 1 • AA	דווחי	TAGION	, FID 2	.0/44
	Danie A.	0.0	MUN 2 / /////	PRAFT.	AT.	STATE OF THE PARTY									

			State of Maryland / Depart			, ,	000-	Ψ
		-1	1. Decedent's Name (First, Middle, Last)	ificate of D	2.	Reg. Date of Death		3. Time of Death
	Physici /Medic		Rudolph Augustus Miller		M	Month March 21	Day 2007 Year	11:17 P.M
	Examin		4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital	4b. City, Town, or L	_		4c. County of Death	
	Funeral	4	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year		. Date of Birth (Month, Day, Ye		hplace (State or Foreign untry) Jamaica
	Director		579–78–6315 AM 201 65 Yrs.	Months Days		ebruary		tego Bay,
	/land ow at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locat	tion				10d. Inside City Limits
	e Man 3a-f sh tiffied	Director	Maryland Prince Georges Adelph	i				1 X Yes 2 □ No
	with th			10f. Zip Code	2		Citizen of What Co	•
	ms 23	Funeral	7909 – 25th Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	20783 as Decedent of His	spanic Origin? (Specif n, Mexican, Puerto Ric		United Sta	rican Indian,
320	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fu	1 Never Married 2 Married 1 Yes 2 No		Specify:	can, etc.)	Black, White Specify:	e, etc. Black
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landz	be filed Ital Hygi d other event, t	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name (F			
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Mary	and 2 sh ealth and n 27 is n		Daughtery	'	nd Number or Rural F ane; Gaith	•		, ,
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g	permit. Page Department of Important: If any injury or once,		21. Signature of Fungral Service Licensee	N. Hort Kenned Kenned	s of Facility ton Compan ly Street,	y Mortic N.W.;Was	ians, Inc	c. 20011
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POX	death certificate be executed e attending physician and d for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	ctopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
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cord	v requires been sign should be	eted	HYDERTENSION					obably 4 Unknown
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VItal	ysician: The lav is certificate has director, page 2.3	Be C	25. Was case referred to medical examiner?		26. Place of Death (0	1□ Yes 2 Check only one)	No 1 □Yes	No No
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UIVISION	I or Attending Physician: after death. Director: After this certifica in by the funeral director, I	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street building, etc. (Specify)	t, factory, office	28f	f. Location (Stree City or Town, S	t and Number or Ru State)	ıral Route Number,
ב	pital cours af	Cel	29a. Certifier Certifying Physician: To the best of my knowledge, death or	occurred at the time	e date and place an	d due to the caus	ea(s) and manner as	stated
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Strature and title of certifier	29c. License	number 928V	29d.	Date signed (Month	n, Day, Year)
2	(7)	ì	30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	int)	oma Pa	046 ~	10-20	012
1	Sto	to.	31. Date filed (Month, Day, Year) 32. Registrar's Signal	, Ink	אוז לאוזרט	TC,	10-00	112
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Physician Ruth Τ., McVev March 21, 2:15 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Health Care Frederick Frederick 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Dec. 13, 19 Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F 168-54-5415 94 Director 1912 Iowa Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits тs 23a or 28a-f show must be notified at Director 1 ☐ Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5955 Quinn Orchard Rd. 21704 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home Pages 1 and 2 should be filed v thent of Health and Mental Hygie tant: If item 27 is marked other t jury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred Miller ဥ Ida Μ. Edlman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) McVey 507 Westway Dr. / Kerrville, Texas Gary 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Agency Cemetery 03/29/2007 Agency, Iowa 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD Maron (anelle 21702 Mure 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** (or as a consequence of): WEFK /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FFMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Dav Year 5 Other (specify) Division or Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown arten 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2[25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: Medical Certification; To 1 Yes 2 No 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. dititle of certifier 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 5hah 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DONJON State MAR 2

Registrar

			For State Registrar	State of I	Marylar	-			ealth a Death	nd Me	ental H	ygier Reg. N) 7	the constraints	193
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	/Medic Examin		4a. Facility Name (If not institution, give		er)		4b. City	, Town, or	Location of			-	c. County	of Death	17-7-7-7	
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<u>la</u>		ပို	Arthur H. Mummen	dey					Anna	Hufe	r					
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Baltimore,	of the state of		20a. Method of Disposition	Domoual from Ctr		Place of Dispersion of Dispers			Θ)	Da		20c.	Location -	City or T	own, State	
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o			27. Manner of Death	28a. Date of (Month,		28b. Time o		28c. Injur	y at		8d. Describ				Living	
O	E = F =	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	1	Day Year)	Injury	м	Wor 1 □	k? Yes 2∐N	No						
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	To the Hospital or At within 24 hours after of to the Funeral Direct completely filled in by	edicai C	29a. Certifier (Check only one) 2 ☐ Medical Exam	ysician: To the bas and manne	is of examin	owledge, dea ation and/or in	th occurre nvestigation	d at the tir in, in my o	ne, date and pinion, deat	d place, ar h occurred	nd due to the dat the time	ne cause e, date a	(s) and ma and place, a	nner as	stated. to the cause)(s)
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U	1+1		30. Name and address of person who Husna Baksh, M.D.	completed cause 10801	of death (Ite Locky	m 23a) (Type VOOd D1	Print)	#280), Sil	.ver	Sprin	g, M	ID 209	01		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** MARCH 23, 2007 6:25 HELEN MANISCHEWITZ /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2√□ F JULY 11, 1911 Director 95 OHIO 150-34-8295 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ont: If item 27 is marked other then "natural", or Items 23e or 28e-1 ehow 10b. County 10d. Inside City Limits 10a, State 10c. City. Town or Location ir then "natural", or items 23e or 28e-f ehow the Medical Examiner must be nutified at 1 X Yes 2 □ No ROCKVILLE MONTGOMERY Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6105 MONTROSE ROAD 20852 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: WHITE Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MATH TEACHER JR. HIGH SCHOOL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HARRY TOUFF SADIE FLECK 2 permit. Pages 1 and 2 shoul Department of Health and Mu Importent: If item 27 is mark eny injury or other traumati once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10500 ROCKVILLE PIKE #701, ROCKVILLE, MD JACK MANISCHEWITZ/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State JUDEAN MEMORIAL GRDNS 03/25/2007 OLNEY, MARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fur Tai Savice Licensee 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** remer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ā Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an has autopsy performed? 1 Yes 2 No this certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Viursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 ☐ Yes 2 No ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and itle of certifier 00367/6 of death (Item 23a) (Type, Print) who completed cause Nockij 10 Md 20852 Montrase Road 6121 Registrar's Signature 31. Date filed (Month, Day, Year) MAR 2 6 State Registrar

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	Physici /Medic		Decedent's Name (First, Middle, Last, Tiffany Ann	Morgan						2. Date of De Month 3/21	eath Day	Year	3. Time of Death 10:15 A ^M
	Examir		4a. Facility Name (If not institution, give 124 Boy Scout Rd.				0ak	Location of			4c. Cou	inty of Death	
	Funeral Director		5. Social Security Number 6. Sec 212-41-3797	7. Age (In y	rs. last birthday)	Months	Days	If Under 24 Hours	Min.	8. Date of Bir (Month, Da 11/3/	ay, Year)	Coul	place (State or Foreign ntry) yland
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9800	within 72 hours after deeth with the Maryland ene. than 'natural', or items 23a or 28e-f ahow ha Madical Examiner chast be multiled at	þ	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		Was Deced If Yes, spec 1 ☐ Yes			n? (Spe Puerto I	icify Yes or No Rican, etc.)		Race - Americ Black, White, ecify: Wh	
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28e-f ahow any figury or other traumatic avent, the Medical Extending on a 100ce.		19a. Informant's Name/Relationship (Ty Terry Morgan/ Fathe 20a. Method of Disposition 1 ♥ Burial 2 □ Cremation 3 □ R	er 20t		Boy S	Scout	Rd.,	0a	Route Numb kland, ate	MD 215		
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	To the Hospital within 24 hours a To the Funeral C completely filled it	Medical	29a. Certifier 1	ician: To the best of my ker: On the basis of examinand manner stated.	nowledge, death nation and/or inv	estigation,	it the time in my opi	nion, death	place, a occurre	nd due to the d at the time,	cause(s) and date and plac 29d. Date sig	e, and due to	the cause(s)
	F 3 F 8		30. Name and address of person who co	mpleted cause of death (II	ет 23а) (Тура.	D2	27205				3/2	3/0	7
	Sta Registra	_	Karl E. Schwalm, 31. Date filed (Month, Day, Year) MAR 2 3 20	M.D. 311 N	Fourth		et C	aklan	d, N	4D 215	550		

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dana Erwin Morris SR narch 200 15:05 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) July 12 19 7. Age (In vrs. last birthday) **Funeral** Months 215-56-8548 1 € M 2 □ F 55 1951 West Virginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD. Allegany 1 ☐ Yes 2 ☑ No Westernport Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22303 Ripken Lane 21562 United States by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hair Styling Barber 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Morris Hazel Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessica Dorsett/ daughter 422 Walnut St., Westernport, Maryland 21562 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ty⊒Burial 2 ☐ Cremation 3 ☐ Removal from State Westernport Maryland Philos Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home de 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** day /Medical Examiner Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the אוייליין אבר Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No perform this certificate Kespiratory il or Attending Physician: after death. I Director: After this certifica 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 27. Mapher of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year)

MCYLL 15Th 2667 29b. Signature and title of certifier D 19318

State

31. Date filed (Month, Day,

517, old town

ss of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Road, Comberland, Md 21502

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiené U 1 - For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March 22,2007 **Physician** 1:42 p M Sue Lorene Miller /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles 3615 Spring Lane Indian Head Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1□M 2√2F Months Min. Yrs. 217-30-0143 89 Sept.26,1917 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 ☐ Yes 2X No Director Maryland Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20640 U.S.A. 3615 Spring Lane Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 【▼No Specify: Specify: 3 ₩idowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Waitress 8 Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Tula Mullins William Lee McNeil ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6225 Ripley Rd., LaPlata, Md. 20646 Daughter Jane Lockwood 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 27,2007
Metropolitan Funeral Service 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Alexandria, Virginia 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Service License M00668 | 4270 Hawthorne Rd., Indian Head, Md.

23a. Part1. Entey the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dilure. List only one cause on each line. 20640 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) he ceet cargestive tai ler Due to (or as a consequence of): Hypertellsed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 🗆 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) ů 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation M 2 C Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Examiner physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the as certificate After thi death. I Director: within 24 hours a To the Funeral C To the Hospitel

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. sht: If item 27 Is marked other than "netural", or Items 23a or 28e-1 show

Baltimore, Maryland 21215-0036

th and Montal Hygiene.
7 Is marked other than "netural", or Items 23a or 28e-f show treumstic event, the Medical Examinar must be notified at

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Physician

/Medical

State Registrar

29b. Signature and title of certifier

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0056949

29d. Date signed (Month, Day, Year)

23/0

07-02525 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Keith Edward Martell State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Month Day April 2, 2007 Medical Examiner 1908 hrs Keith Edward Martell 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 17022 Shinham Road Washington Hagerstown 5. Social Security Number If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year Months Days Hours Director 1X X M 2 F 43 June 4,1963 Newtrylersey 178-60-9340 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Yes 2 X No 28a-f show or items 23a or 28a-f shormust be notified at once. Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17022 Shinham Road Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black Armed Forces? White, etc. 1 Never Married 2 Married 2 X No Yes 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: Examiner White 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) I and 2 should be filed within 72 h Health and Mental Hygiene. Fitem 27 is marked other than "n Binding Company Folder Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ronald Earl Martell Betty Jane Holsopple 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty J. Martell - Mother 12068 National Pike Clear Spring, Maryland 21722 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Burial 2 X Cremation 3 Removal from State Smithsburg Crematory Apr.3,2007 Smithsburg, Maryland Signature of Funeral Ostorne Adfament Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and sician/Medical X UNPENDED #23a,27,perME, ending physician use as the burial g866. 4/10/07 TT Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö þ Yes 2 No 3 Probably 4 V Unknown ۵. Completed Records, has been 24b. Were autopsy findings available 24a. Was an prior to completion of cause of performed: death? page ✓ Yes 2 1 Yes 25. Was case referred to medical 26 Place of Death (Check only one) To the Hospital or Attending Physician: of Vital Be Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 this 1 V Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Division 1 Yes 2 No 5 Pending in by the Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City within 24 hours after To the Funeral Direc 6 Could not be Suicide or Town, State) Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d, Date signed (Month, Day, Year) 29b. Signature and title of certif 29c. License number April 3, 2007 O.C.M.E. 30 Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Laron Locke MD.

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. R gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 5:32 P M Thelma Ruth Musser March 26 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Washington 19333 Longmeadow Road Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Months 1□M 2√2F 196-05-3639 91 Sept.15,1915 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√XNo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17301 Broadfording Road 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. t Never Married 2 Married 1 Yes 2 No Specify Specify: 3√Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert Wert Edith Lewellyn Steward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Kinslow - Daughter 361 Daycotah Avenue Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park Mar.29,2007 Hagerstown, Maryland 21. Signature of I neral Ser Osborne Adress e Faily Home, P.A. 425 S. Conococheague St. Williamsport, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acute Myocardial immediate 3d. Date of delivery Month se contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other (Granddaughters deurred

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg important: if liem 27 is marked other any injury or other traum...... **Physician** /Medical Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

10a. State

Director

Funeral

Completed by

Be

Funeral

Director

Item 27 is marked other then "naturel", or Items 23s or 28s-f show other traumatic event, the Mudical Examplement the notified at

death with the Maryland

filed within 72 hours after

Maryland 21215-0036

completely filled in by

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Division of Vital Records, P.O. Box 68760,

resulting in death)	a. 10-11-C	1000	- C 11	2000 -1160	,		In
	Due to (or as a conse	quence of):	1 5	1.110			
Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse		NOT TO	attore			
	d						
fF FEMALE: 23b. Was decedent pregnant in the past 12 months2 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 □Ectopi	c pregnancy (specify)			23d. Date of d Month	delivery Day
Part II. Other significant conditions of	contributing to death but not re	sufting in the underlying	g cause given ir	Part I.	23e. Did tobacco	- ^	to the ca Probably
					24a. Was an autopsy performed?	death	o comple
25. Was case referred to medical examiner?			26	. Place of Death (C	Check only one)		
1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other:	4 🗌 Nursing Home	5 Residence	Other (S	icano
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio		28b. Time of Injury M	28c. Injury at Work?	280 2 🗆 No	d. Describe how in	ury occurred	
3 Suicide 6 Could not be determined		nome, farm, street, fac ify)	tory, office	28f	Location (Street a City or Town, Sta	and Number or l ite)	Rural Ro
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of my kn miner: On the basis of examin and manner stated	owledge, death occur ation and/or investiga	ed at the time, of ion, in my opinio	date and place, and on, death occurred	I due to the cause(at the time, date a	s) and manner and place, and de	as stated ue to the
29b. Signature and title of certifier	Della Company	-	29c. License nu	00101	29d. C	ate signed (Mo	nth, Day,

10H-4 State Registrar

within 24 hours a To the Funerel C

31. Date filed (Month, Day, Year) MAR 28 2007

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

iccarelli

Drive

Number or Rural Route Number,

signed (Month, Day, Year)

Williamsport MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 200^Y2^{a1} **Physician** Month March 2day 7:20 AM NORMA CELTA PEIGH /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner College View Center Frederick Frederick If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. Months 1 □ M 2 🕅 F Hours Director 15, 1932 Maryland 214-30-0679 74 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Frederick Monrovia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21770 4999 Tall Oaks Drive USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or Items 23 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 X No 1 ☐ Yes 2 X No Specify Specify. þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u> Administratice Assistant</u> Publishing Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental I Important: If Item 27 is marked ot any Injury or other traumatic ever Be Earle Erickson Osmond Eileen E. Broadhurst 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4999 Tall Oaks Drive, Monrovia, Maryland 21770 David W. Peigh, husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 4/26/2007 Smithsburg, Maryland 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney and Basford Funeral Home 21. Signature of F M00999 106 East Church Street, Frederick, MD Approximate Interval Between Onset and Death 23a. Part . F ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, it heart failure. List only one cause on each line. Immediate Cause Final disease or continuo Toabable **Physician** disease or con-resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ne ox 68760, Eg Exami and resulting in death) Last Due to (or as a consequence of) inding physician a use as the burial Physician/Medical use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? Day signed by the at d be detached for 1 ☐ Yes 2 ☐ 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2☐N6 3☐ Probably 4☐Unknown 1 ☐ Yes plnous Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 perform certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ NO 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 28d. Describe how injury occurred 27. Manner of Death 28a Date of Injury 28b. Time of 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide

Box 68760, P.O. or Vital Records. spital or Attending Physisiours after death.
ineral Director: After this y filled in by the funeral di Division within 24 hours a

To the Funeral I To the Hospital

Baltimore, Maryland 21215-0036

Medical

29a. Certifier

(Check only one)

Hemen

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) APR 0 9 2

State

Registrar

homa

MB

32. Registrar's Signature

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shal

9 2007

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

0060UI

29d. Date signed (Month, Day, Year)

21707

			For State Registrar	State of N		id / Depa		t of H	ealth a			jiene leg. No.	07	1120)2
Н	Physicia	an	1. Decedent's Name (First, Middle, Last	7		PHI					2. Date of Dea	th Day	Year	3. Time of De	ath
	/Medic	al	CHARLOTT	<u> </u>	-1	TH/		_		15 11	05	10	oty of Death	0411	M
je.	Examin	er	4a. Facility Name (If not institution, give Adelphi House	street and numbe	")			ielpi	Location o	Death				orge's	
	Funeral Director		5. Social Security Number 6. Se 579-27-3230	X 2 X F 7. /	Age (In yrs. 89	last birthday) Yrs.	If Under Months		If Under :	24 Hrs. Min.	8. Date of Birt.	1 ⁴ 9 ⁴ 1 ⁷ 7	9. Birth	place (State or F ptry) bados	oreign
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							IOd. Inside City I	Limits
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	r 28a	Director	10e. Street and Number				10f. Zip	Code			T	10g. Citizen o	of What Cou	ntry?	
	fh wit	al D	216 Rittenhouse S	treet, N	.W.			200	011			U.	S.A.		
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21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itema 23a or 28a-f ehow ha Madical Examinar must be notilled at	ed b	15. Decedent's Ed	Year or Dates	S.	16a. Dece	dent's Usua	al Occupa	ation			16b. Kind of	Business/In	dustry	
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Baltimore, Maryland	be filed htal Hygid od other event, II	Be	17. Father's Name (First, Middle, Last)								(First, Middle,		ame)		
yla	ould I Men narke	٩	Emmanuel James				171				a Josep				
Mai	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship (T			216 F	Ritter	nhous	se St	reet	N.W.	r, City or Тои	m, State, Zij	Code)	
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Iteme 23a or 28a-f show any figury or other traumatic event, in a Medical Examinat must be notified at angle.		Elva Backley/daug	nter	20b. F	Place of Dispo	inston sition (Nar	ne of			ate	20c. Locatio	n - City or T	own, State	
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Division of	To the Hospital or Attend within 24 hours effer death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building,	etc. (Speci	fy)					City or Tov	m, State)		al Route Numbe	r,
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1	(1)		30. Name and address of person who d			m 23a) (Type,	Print)						-1-1		
			Michael J. LaPe					hway	, Ann	apo1	is, MD	21401			
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			For State Registrar	State of Ma	aryland / I		ent of Hea ate of De			giene Reg. No.	07	11203
e 18	Physici	an	1. Decedent's Name (First, Middle, Las	it)					2. Date of Dea	ath Day	Year	3. Time of Death
	/Medic	_	Catherine		ne				March	26, 2	007	2:30 P M
6	Examin	ier	4a. Facility Name (If not institution, give	· · · · · · · · · · · · · · · · · · ·			y, Town, or Loc				y of Death	
-	Funeral		Holy Cross Holy Social Security Number 6. S		e (In yrs. last bi		ilver S er1 Year f	pring Jnder 24 Hrs.	8. Date of Birt (Month, Da		tgomer 9. Birthpl	ace (State or Foreign
и.	Director		212-68-2756	□M 2 X F	52	Yrs. Month	s Days H	ours Min.	Sept. 1	y, Year) 3, 1954	Coun	ington,DC
	pu ,		Usual Residence of Decedent		10c. City, Tow	m or Leastion						N 1-11-01-01
	show show	٦	10a, State 10b. County	. 1							1	od. Inside City Limits 1 X Yes 2 □ No
	the M 28a-f 10tiffe	rect	Maryland Freder 10e. Street and Number	ICK	Mour		Zip Code			10g. Citizen of	What Coun	
	3a or	Funeral Director	706 Bridlewreat	n Wav		102	21771			United		_
	ms 2	nera	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13. Was Dec		nic Origin? (Sp	ecify Yes or No Rican, etc.)		ce - America	an Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	10		_	pecify:	rican, etc.)		ack, White, e fy: \to Wh	
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Vital		Be C	25. Was case referred to medical				26.	Place of Deat	1 Yes th (Check only o	2 X No	1 ☐ Yes	2 No
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n or	ng Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	ry 28b. y Year)	Time of Injury	28c. Injury at Work?		28d. Describe	how injury occu	ırred	
Sio	tendleah. tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be			M	L	2 □ No				
Division	ta or A	Certification:	4 ☐ Homicide determined	28e. Place of inju building, etc	c. (Specify)	arm, street, ract	ory, office		City or To	Street and Nun wn, State)	nber or Hura	l Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example 1	ysician: To the best on niner: On the basis of and manner sta	f examination a	je, death occurr nd/or investigat	ed at the time, of ion, in my opinion	date and place on, death occu	, and due to the rred at the time,	cause(s) and r date and place	nanner as si e, and due to	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	, ,	+	2	29c. License nui	mber		29d. Date sign	ed (Month,	Day, Year)
			Stanley a	Schvar	4 0		D 17368	3		March	26, 2	2007
15			30. Name and address of person who	completed cause of d	eath (Item 23a)							906
//			Stanley A.	Schwartz,	MD / 21 ar's Signature	01 Medi	cal Par	k Dr.,	Suite #	200/	Silver	Spring,MD
	Sta		31. Date filed (Month, Day, Year) MAR 2 7 2	nn7	ar a digriature	breek						

			For	State of M	aryland	/ Depa	artmen	t of H	lealth a	ınd Me	ntal Hy	giene	0 0 0	6 771		0.1
		_	1 - State Registrar			Cei	rtificate	e of L	Death		i	Reg. No	200	1	1 2	204
			1. Decedent's Name (First, Middle, La	nst)						2	Date of Dea	ath Day	Ye	25	3. Time of	Death
	Physici /Medi		Helen	Paster	nak	-				1	Var	20	20	7	1255	Рм
	Examir		4a. Facility Name (If not institution, given				4b. City,	Town, or	Location of	f Death	900	4c.	County of D	eath		
			Shady Grove Adve	entist Hos	pital		Rock	vil]	le			Мо	ntgom	erv		
	Funeral		5. Social Security Number 6.	Sex 7. Ag	ge (In yrs. las	t birthday)	If Under Months			24 Hrs. 8 Min.	. Date of Birt (Month, Da	h			ce (State o	r Foreign
н	Director		198-20-5344	1□M 2XF	82	Yrs.	Months	Days	Hours		ec. 25,		4 P		ylvar	nia
	D.		Usual Residence of Decedent													
	how I at	_	10a. State 10b. County		10c. City, T	lown or Lo	cation							100	 Inside Cit 1 ☐ Yes 	
	e Ma Sa-f s	cto	Maryland Montgom	ery	Rock	ville	2									220110
	or 28	Jire	10e. Street and Number				10f. Zip	Code				10g. Citi:	zen of Wha	t Country	y?	
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show with the Medical Examiner must be notified at	Funeral Director	9701 Veirs Drive					850				USA				
	ems	inei	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Deced	ient of Hi cify Cuba	ispanic Orig	gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)	-	 Race - A Black, V 			
9	afte or it	F	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🔀 If Yes, Give	No		1 ☐ Yes 2		Specify:				Specify: V	Th 4 +	_	
21215-0036	ours iral", LExa	d by	3 Widowed 4 □ Divorced	Year or Dates:												
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21	ithin ne. han e Me	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Clerk							Danie	g Stoi	• •					
	led v lygie her t		12	41		C	1erk		19 Motho	r'e Name (First, Middle,					
ng	be fi ntal F dotl ever	Be	17. Father's Name (First, Middle, Las							Krup		Maluen	Surrianie)			
Σį	ould Mer narke	ို	Joseph Grexa,		1			/2: :						. =: 0		
Maryland	2 sh and Is r		19a. Informant's Name/Relationship								Route Numbe				,	
	and lealth m 27 her t		Donald H. Anders	on – exec			Kouno sition (Nan		ut wa	y Spr	ingfie		cation - City			
ore	ges 1 t of h if ite or ot		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 [☐Removal from State	cerr	netery, crei	natory or o	ther plac								
Ē	men tant:		4 □ Donation 5 □ Other (Spec		Gran		Ceme				,2007					vania
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Turieral Service Lice			. 1					ent Fu					
	20 - 20		TI AGEMI		ncogs						Church		. 220	1		
и			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that cause vone cause on each l	d the death. ine.	Do not ent	er the mod	e of dyin	ng, such as	cardiac or	respiratory a	rrest,] [Approximat nterval Bet Onset and I	ween
	Physician		Immediate Cause (Final disease or condition	- Pne	umo	mi	~							L	da	45
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Division	or A after Direction by	i iii	4 ☐ Homicide determine	building, e	etc. (Specify)	ic, iaiiii, sii	eet, lactory	y, office		20	City or To			or murar	noute Ivali	iber,
	Hospital or 44 hours afte Funeral Dir tely filled in	ပိ	29a. Certifier 1 Certifying F	Physician: To the besi	t of my knowle	edge deat	h occurred	at the ti	me date an	nd place as	nd due to the	callee(e)	and mann	er ac eta	ted	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical Certification:	(Check only one)	aminer: On the basis	of examinatio	on and/or in	vestigation	n, in my	opinion, dea	ath occurre	d at the time,	date and	d place, and	due to	the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	and manner o			290	c. Licens	se number			29d. Da	te signed (A	Aonth, D	ay, Year)	
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			30. Name and address of serson who	o completed cause of	death (Item 2	(Type				, , , _		(VC)	0,(000	- (
		1	The state of the s			-, (.,) -,										

State Registrar Brian Carpenter
31. Date filed (Month, Day, Year)

MAR 2 3 2007

9901 Medical Center Drive, Rockville, MD, 20850

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** April 3, 2007 MABEL FRANCES OUESINBERRY 10:40AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Sunshine Acres Norrisville Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9/3/1916 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕱 F Yrs. Director 217-20-7322 90 Virginia Usual Residence of Decedent the Maryland r 28e-f show 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Jarrettsville MD. Harford Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with tand Mental Hygiene.
Is marked other then "netural", or iteme 23a or 2 eumatic event, the Madical Examinat must be not matic event. 2409 Lemon Road 21084 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16h Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Housewife 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Calvin Deboard Emma Theoria Blevins ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 is m eny injury or other treum 90028. Dorothy P. Deboard/Niece 2808 McComas Road White Hall, Md. 21161 20a. Method of Disposition
1 ABurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4/6/2007 Madonna, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bethel Cemetery 21. Signature of Funeral Service Livery ee 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Alzheimer's Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, issuing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dualty for as a consequence off Examiner Bu attending physicien end for use as the burial-transit The taw requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2X No 3 Probably 4 Unknown caretravasanar disease Completed been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 s certificate has 2 No 1 Yes 2 No 1 Tyes Physician: Be 25. Was case referred to medical director 26. Place of Death Check only one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Hospitel or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funerel Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 44 a Brema MD 4/5/07 D0057957 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3346 Paper Mill Rd Phoenix MD 21131 Jake A Dietnich 31. Date filed (Month, Day, Year) APR 0 9 2007 32. Registrar's Signature State GOSAL) Registrar

		For State	State of M	laryland		artmen					giene Reg. No. 2	007		206
77.5	-	Registrar 1. Decedent's Name (First, Midd	fle. Last)			inout				2. Date of Dea	ath	0 1/1	3. Time of I	Death
Physic	cian	CLINTON	RAY							Month MARCH	22 Day	2007	1905	М
/Med		4a. Facility Name (If not instituti		•)		4b. City,	Town, or	Location	of Death		4c. C	ounty of Death	1	
Exam	iner	Southern Mary				C1i	intor	1			Pri	nce Geo	orges	
Funera		5. Social Security Number		ge (In yrs. la	st birthday)	If Under		If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h	9. Birth	place (State or	r Foreign
Directo	1	577-76-7669	1 ½ M 2□ F	52	Yrs.	IVIOTILITS	Days	Tiours	IVIII I.	Oct. 2			ginia	
P.		Usual Residence of Decedent		10c City	Town or Lo	cation				· ·			10d. Inside Cit	ty Limits
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urs af	P P	3 □ Widowed 4 □ Divorce	If Yes, Give	1973 197	79	1 🗆 Yes	2 ½ No	Specify	:			Specify: B.	lack	
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t. Pa tmen tant:		4 □ Donation 5 □ Other		Qua	antico							ingle,	VA.	
oermit. Pages 1 ar Department of Hea Important: If Item any injury or othe	ouce.	21. Signature of Funeral Servi	De licensee	2						Home,		n D C	. 20011	
202 0	<u> </u>	23a. Pagl. Enter the disease shock, or heart failure. L	or complications that caus	sed the death	n. Do not er	+217	de of dyi	ng, such a	IN . W .	or respiratory a	arrest,	ni, D.C	Approximat Interval Bet Onset and	te
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he law requires to has been signed age 2 should be o	Completed	-		V						24a. Wa aut	s an opsy formed2	prior to death?	completion of	cause of
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eatler:	Certification:	2 Accident Inv 3 Suicide 6 Co	estigation Ild not be 28e Place 0	f injury - At h	ome. farm.					28f. Location	(Street an	d Number or F	Rural Route Nu	ımber,
or Attendate death Director:	1	4 ☐ Homicide del	ermined building	, etc. (Speci	fy)					City or T	own, State)		
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2		30. Name and address of per	son who completed cause	of death (Iter	m 23a) (Typ	e, Print)	0.	, L 2:	n 1.	Janking	h.)c 200	35	
		31. Date filed (Month, Day, Y	- M) 1328 Jo	juh em gistrar's Sign	atur#	ne st	261	115 311	U V	ייייייייייייייייייייייייייייייייייייייי	IDM S) COU	16	
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State of Maryland / Department of Health and Mental Hygiene) State
Registrar AMEND#20bperFH3/26/07, HWW, MbCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 15 **Physician** Richmond James 2007 March 9:20 AM /Medical 4a. Facility Neme (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Fort Washington Prince George's Fort Washington Hospital tf Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Sociat Security Number 7. Age (In yrs. last birthday)
77 Yrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Sountry)
March 20,1929 Mebane, Birthplace (State or Foreign Country) **Funeral** 150 M 2 □ F 232-30-8044 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "neturel", or iteme 23e or 28e-f ehov Ite Medical Examinar must be motified at 1X Yes 2 ☐ No Director Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 USA 12021 Livingston Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Btack, White, etc. Pages 1 end 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☑ No tf Yes, Give 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2½ No Specify: Specify: Black þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) Construction Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Giles Richmond Susan Baines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 6260 Brimfiel9 Place, Port Tabacco, MD 20607 Felix Cummings -Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition important: if it any injury or o once. 3/25 Burial 2 ☐ Cremation 3 ☐ Removal from State ./07 Sweet Gum Bapt. Church Mebane, NC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home Dolleum 3831 Georgia Ave., NW, Washington, DC 20011 Approximate Interval Between Onset and Death 23a. First. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) preemia **Physician** /Medical Due to (or as a consequence of): Examiner Myran Mail Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the attending to for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a ld be detached f ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 2 PNo 1 Tes 3 Probably 4 Unknown Completed should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate hes page 2 s autopsy performed 1 Yes 2 No this certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No į 2 ER/Outpatient ပ္ 3 DOA tor: After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manper of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation Natural death. 1 Tyes 2 No 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Illed in by 4 Homicide within 24 hours e To the Funeral I completely filled To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) March 10055120 144) 15 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Southern avenue & Sut 310 Was ling for D c 2003 Richard Palmer mo 1328 31. Date filed (Month, Day, Year) State MAR 2 6 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Day Louis Leonard Ruben March 21, 2007 9:52 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Months Hours Min. 579-20-3022 81 March 24, 1925 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Schindler Court 20903 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ♣ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify. 3 Widowed 4 Divorced Year or Dates: WWII White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Judge Court 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Ruben Estelle Jennie Cohen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ida G. Ruben - Wife 11 Schindler Court, Silver Spring, Maryland 20903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Judean Memorial Gardens 3/25/2007 Olney, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate
Interval Between
Onset and Death The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Day Year the cause of death? bably 4 \(\pi\)Unknown

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

'natural",

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Important: If Ite
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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

burial-tran physician use for ģ

Physician/Medical

Completed by

Certification: To Be

Medical

State Registrar 29b. Signature and title of certifier

rank

Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

GrayINO

completely

After this certificate has been signed | funeral director, page 2 should be det certificate has After this within 24 hours after death To the Funeral Director: filled in by

or Attending Physician: The law requires that the death certificate be executed

To the Hospital

Division or Vital Records, P.O. Box 68760,

Immediate Cause (Final disease or condition resulting in death)	a. Myocordial Infarction Due (or as a consequence of):		Onset and Death Minutes Many
Se uentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):		Years
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		ate of delivery Ionth Day Year
Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use cor 1 ☐ Yes 2 No	atribute to the cause of death?
		24a. Was an autopsy performed? 1 Yes 2 No	. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?		ath (Check only one)	22111112
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	lome 5 ☐ Residence 6 ☐ Ot	ther (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 28b. Time of Injury at Work? Month, Day Year 28b. Time of Injury 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury occu	ırred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Num City or Town, State)	ber or Rural Route Number,
29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my knowledge, death occurred at the time, date and place iner: On the basis of examination and/or investigation, in my opinion, death occurred manner stated.	e, and due to the cause(s) and nurred at the time, date and place	nanner as stated. e, and due to the cause(s)

29c. License number

		1 - For State Registrar	State of	f Maryland	•			ealth a Death		•	giene Reg. Nó	2007	11209
Physicia	n	1. Decedent's Name (First, Middle, Li	•	Dahahan	~ L					2. Date of Dea		2007 ^{Year}	3. Time of Death
/Medic Examine		Charles Rob 4a. Facility Name (If not institution, gir Garrett County M	ve street and nun				Town, or	Location o	of Death	March		County of Dea	ath
Funeral Director		5. Social Security Number 6. 213-01-4082		7. Age (In yrs. Ia 89		1	r 1 Year	if Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 12/24/	y year) 1917		irthplace (State or Foreig Country) st Virginia
5-0036 72 hours efter death with the Marylend 72 hours efter death with the Marylend neturel; or iteme 23s or 28e-f show dical Examiner must be notified at	Director	Usual Residence of Decedent 10a. State 10b. County MD Garre	tt		Town or Lo						10d. Inside City L 1 ☐ Yes 2		
e 23a or 2		10e. Street and Number 234 Hotel Road	10 Mes Door	adopt Ever in U.S.	10	10f. Zip	21	550	-i-2 (6		10g. Citizen of What Country? USA or No- 14. Race · American Indian,		
OSO ours efter do rel', or item Examinar	by Funeral	11. Marital Status 1 Never Married 2 Married 3 WWidowed 4 Divorced	Armed For			was Dece f Yes, spe 1 ☐ Yes		Spanic On n, Mexicar Specify:	gin (Spe i, Puerto	ecify Yes or No- Rican, etc.)		Black, Wh	
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Ore, Maryland Z es 1 end 2 should be filed of Heelih end Mental Hygle filem 27 is marked other r other treumetic event, it	To Be C	17. Father's Name (First, Middle, Las	n Rohrb	augh		41 III		18. Mothe		(First, Middle,		Sumame)	inberger
5 3 8 E		19a. Informant's Name/Relationship Delbert Paugh/ Ne 20a. Method of Disposition		20h. Pia		Ben	DeWi		., 0	A Route Number	MD		
It In the street of the street		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	fy)	State Cer	netery, crei • O • F •	ceme	ther place tery		3/19		E1k	Garder	ı, WV
Deperment of the permean of the perm		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that ca	aused the death.	ļii	32	S. S	econd	St.	, Oakla	ind,		
deeth certificate be executed With the second control of the seco	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. athe Due to (b. Chro Due to (c. Diak	eroscle or as a conseque onic in or as a conseque oetes m or as a conseque	ence of): ters ence of): uelli	titi					ease	9	Onset and Death yrs yrs 16 yrs
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tal or Attending tal or Attending s after death. el Director: Atte ed in by the fune	Certification;	3 Suicide 6 Could not to determined	28e. Place buildir	of Injury - At hom	ne, farm, str	eet, factor	, office		2	28f. Location (S City or Tow			Rural Route Number,
To the Hospitel of within 24 hours at To the Funerel D completely filled i	edical	29a. Certifier (Check only one) 1 Medical Exa	miner: On the ba and mann	asis of examination	ladge, ceatl on and/or in	estigation	, in my op	inion, deal	d place, a th occurre	ed at the time, o	date and	place, and du	e to the cause(s)
To t To t com	Σ	29b. Signature and title of certifier	Hoh	h. D		D	3003					e signed <i>(Mon</i>	
		30. Name and address of person who Donald R. Ricl	nter, M	1.D. 15	33 M		ial	Dri	ve C	akland	d, h	MD 215	550
Stat Registra	-	31. Date filed (Month, Day, Year) MAR 1 9		egistrar's Signatu	re	Carro Mi		٠	,				

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 03 Day 19 Үеа 07 **Physician** 2130 Shockey Agnes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland WMHS Braddock Campus If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Funeral Months Days Director Maryland 220-58-0173 February 01, 1916 Usual Residence of 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show ral", or Items 23a or 28a-f shov Ex miner must be notifled at 1 ☐Yes 2 No Director Lonaconing Maryland Allegany 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. Completed by Funeral 15811 Lower Georges Creek Road S.W. 21539 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify. Specify: 3 Widowed 4 □ Divorced 'natural", White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home Ith and Mental Hygie 27 is marked other r traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ Nellie Thomas James Rankin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 17 East College Avenue, Frostburg, Maryland, 21532 Sandra Livengood - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: if It any injury or o once, 1 Burial 2 □ Cremation 3 □ Removal from State March 23, 4 ☐ Donation 5 ☐ Other (Specify) 2007 Cumberland, Maryland Sunset Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 23a. Part). Enter the disease, or of implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** +CUTE LNFARCTION Mycaro disease or condition resulting in death) out loder /Medical Due to (or as a consequence of) Examiner COROWARE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed bunial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the buna Physician/Medical anding use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) ☐Yes 2 No 9 ☐ Unknown signed l 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy s certificate has lirector, page 2 performed' 2 🗷 No 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA P 1 Inpatient this 28a. Date of Injury 28b. Time of uneral 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: d in by the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sidhu 925 Bishop imperland Manyland 21502

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAR 2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State	State of N		epartment of F			200	7 11210
			State Registrar 1. Decedent's Name (First, Middle)	a / act)		Certificate of	Dealli	2. Date of Dea	eg. No. 💪 📗 U	3. Time of Death
п	Physici	an	Mary	Elizabeth	Тмо	chimowicz		Month	Day Year	1- 0
4	/Medic	_	4a. Facility Name (If not institution			4b. City, Town, o	r Location of De	MARCH	3c 2007 4c. County of De	
*	Examin	ier	Washington C		·		rstown		Washin	
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last birth	day) if Under 1 Year	if Under 24 H		9. B	irthplace (State or Foreign
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	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	shov shov	7		hington		onsboro				1 X Yes 2 No
	the M	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What 0	
	with a or	ΙΟ̈́	141 South Mair	Street		217	1.3	[]	U.S.A.	Southly :
	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	Funeral	11. Marital Status	12. Was Decede		13. Was Decedent of I		(Specify Yes or No-	14. Race - An	nerican Indian,
0	or ites		1 ☐ Never Married 2 ☐ Mar	Armed Force				Jerto Hican, etc.)	Black, Wh	
5-0036	ral", c	l by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Date	s:	1 □ Yes 2X No	Specify:		Specify: W	nite
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aryland 2121	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene 1 Health and Mental Hygiene 1 Health and Mental Hygiene 1 Health 23 is marked other than "natural", or items 23a or 28a-f show Item 27 is marked other than "natural", or items 25a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ဥ	19a. Informant's Name/Relations		19b. I	Mailing Address (Street	and Number or	Rural Route Number	r, City or Town, State	, Zip Code)
≥	and 2 sealth ar		Patricia Jabl	onowski, Da	aughter 2	03 Backing	Circle	, Martinsb	ourg, WV	25405
ē,	of Hee	11	20a. Method of Disposition		cemetery	Disposition (Name of crematory or other pla	ce)	Date	20c. Location - City of	or Town, State
Ë	Pages nent of int: If Its Iry or o	l a	1		te I	en Mem Gar		r 3, 2007	Frederick	, Maryland
Baltimore,	permit. Page Department of Important: If any injury or once,		21. Signatur of Funeral Service	Lic nsde		22. Name and Addre	ess of Eacility	ord P.A. F	uneral Ho	me
<u> </u>	89 E E 9	40 9	Fok Jym	Bew	M00706	106 East	Church	St, Freder	ick, Mary	me land 21701
н			23a. Part1. Enter the disease, o shock, or heart failure. List	complications that cause only one cause on each	sed the death. Do no n line.	ot enter the mode of dyi	ng, such as card	diac or respiratory arr	est,	Approximate Interval Between Onset and Death
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8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d	ostridiu	n Driffiel	e Collt	<u> </u>	·	4 weeks
9	ertifica ing ph e as th	Med	IF FEMALE:							
â	leath certific attending p I for use as	Physician/Me	23b. Was decedent pregnant in the past 12 mounts?		2 Fetal death	3 ☐Ectopic pregnand	y		23d. Date of d Month	lelivery Day Year
Records, P.O. Box	the a	/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregnan 9□Unknowi	t at time of death	5 ☐ Other (specify) _				24,
<u>.</u>	w requires that the d been signed by the should be detached	F	Part II. Other significant conditi	ons contributing to deat	h but not resulting in t	the underlying cause gi	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
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ō	ig Ph ter thi	Ë	27. Mannar of Death 1 Natural 5 Pendi	28a. Date of I	njury 28b. Ti	me of 28c. Inju			ow injury occurred	
0	ath. or: Af	atio	2 ☐ Accident invest	gation	Lay roal)		Yes 2 No			
Division or	or Att ter de Irecto	Certification:	3 Suicide 6 Could 4 Homicide determ	ained Zoe. Place of	injury - At home, farr etc. (Specify)	n, street, factory, office		28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
	ospital o hours aft uneral D ely filled ir		COn Continue	- Shusiala - T- th	at of my leaves to d	death approved that	inna data and a	lose and dive to M	anung(a) ar d	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1	ng Physician: To the be Examiner: On the basi and manner	s of examination and	or investigation, in my	opinion, death o	occurred at the time, o	date and place, and d	as stated. lue to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certific			29c. Licen			29d. Date signed (Mo	
			,			D 40	1996		March 3	0, 2007
	7		30. Name and address of person	who completed cause of	of death (Item 23a) (T	ype, Print) appar	s Rd	Boonsbur	O MD	21713
	0		-4-1	- 1- 11 11 1- 10		• •				

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month ANNETTA TATE 11:28A M 2007 MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES 8. Date of Birth (Month, Day, Year) 11/25/1943 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 T F 63 Director 223-58-1901 VA Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medic at Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2\ No Director VA KINSALE 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 112 PECKATONE ROAD 22488 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 and 2 should be filed within 72 hours after thealth and Mental Hygiene. Health and Mental Hygiene. 1 ☐ Yes 2 XNo If Yes, Giv*e* Year or Dates: XXNever Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify ð Specify: BLACK 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 SECRETARY US GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LOUIS B. GREEN EMILY ANN WILSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type. Print) DWAINE TATE/ SON permit. Pages 1 and 2 s Department of Health at Important: If item 27 is any injury or other trau 3939 PENNSYLVANIA AVE SE, WASHINGTON, DC 20020 ANDREA CLINE/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) ZION CHURCH CEMETERY 3-29-2007 KINSALE, VA 21. Signature of Funeral Service Joensee Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD / FISHER F.H. Hans 23a. Part1 Enter shock or heart to... diate Cause (Final condition 4308 SUITLAND RD. SUITLAND, MD / WARSAW, VA Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. ANCER EAST **Physician** /Medical Due to (or as a consequence of): Examiner EUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): ESOPHAGITIS The law requires that the death certificate be executed MOTAION attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2XXNo Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 YUNnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy 1□ Yes XIX No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes XX No မှ 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No filled in by the 6 ☐ Could not be 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) orsoms signing 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSIA 6192 OXON HILL ROAD STE 500 OXON HILL MD 31. Date filed (Month, Day, Year) MAR 2 7 2007 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Registra

Physician /Medical **Examiner**

physician

attending

certificate

After this

within 24 hours after death To the Funeral Director:

To the Hospital or Attending Physician:

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examines

Saltimore, Maryland 21215-0036

Funeral

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Completed

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Certification:

Medical

Division or Vital Records, P.O. Box 68760,

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

5 Pending investigation

1 ☐ Yes 2 ☑ No

27. Manner of Death

1 Natural

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

Due to (or as a consequence of):

Due to (or as a consequence of)

28b. Time of

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

Month Day Year

23e. Did tobacco use contribute to the cause of death? 1 Dres 2 No 3 Probably 4 Unknown

23d. Date of delivery

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 12 No 1 ☐ Yes 2 ☐ No

26. Place of Dea	ath Check only one
Other: 4 Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)
Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
fice	28f. Location (Street and Number or Rural Route Number, City or Town, State)

3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, fac building, etc. (Specify)	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one)				e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)

280

29b. Signature and title of certifier

Hospital:

28a. Date of Injury

(Month, Day Year)

29d. Date signed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9th St; Federik, Md 21701 32. P 31. Date filed (Month istrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 1 Denson Warren 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Oak land

Vear | Hunder 24 Hrs. 802 Oak Garrett Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth Days 15₹M 2□ F 89 232-20-6001 04/07/ West Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Y☐Yes 2☐No MD Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21550 USA 802 E. Oak St. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Bfack, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🕱 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Retail Grocerv Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Benson Warren Unger, Sr. Virginia Bohrer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan M. Unger/wife 802 E. Oak St. Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Thomas, WV Rose Hill Cemetery 4-4-07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Hinkle Funeral Home, Inc. P.O. Box 186 Davis, WV 26260 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Q Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last inflom Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 1 Yes 2 No 1 Yes 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Priysician /Medical Examiner Examiner or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical

Physician

/Medical

Examiner

Director

Funeral

Be Completed by

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 le marked other than "naturel", or Items 23a or 28a-f ahov any highry or other treumatic avent, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

this certificate has been signed by the attending physicien and al director, page 2 should be detached for use as the burial-trai Yo the recent within 24 hours after death.

To the Funerel Director: After this formation by the funeral

Be

Medical Certification: To

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. fnjury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29d. Date signed (Month, Day, Year)

State Registrar

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31. Date filed (Month, Day, Year) APR 0 9 2007

30. Name and address of person who complet

29b. Signature and title of certifier

2. Registrar's Signature

of death (Item 23a) (Type, Print)

/Medical Examiner Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed burial-tran attending physician for use as the buria After this certific funeral director. s after dea...ral Director: Aft filled in by ō To the Hospital or within 24 hours aff To the Funeral D completely filled in

Physician

/Medical

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Certification; To

Examiner

Funeral

Director

if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumation.

Physician

Baltimore, Maryland 21215-0036

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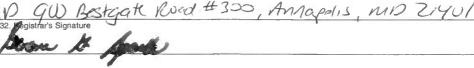
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DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) MAR 2 3 2007

Werner

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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irlos Fonnae V		State of Maryland / D	•		Mental Hy	/giene					
		Registrar	Certificate of Dea	ath		Reg.	No. 9	125-0-1-2-1			
Physicia edical Examin	1107	1. Decedent's Name (First, Middle, Last) Carlos Fonnae	Webb			2. Date of Death Month D March 18, 20		3/Time of Death / 2202 hrs			
		4a. Facility Name (if not institution, give street and number) 9505 Glen Way		t Washin	ocation of Death		4c. County of Dear Prince Georg				
Funeral Director		5. Social Security Number 6. Sex 7. Age (Ir 345 23 8114 1X M 2 F 3		nder 1 Year nths Days	If Under 24Hrs Hours Min.	8. Date of Birth(I	MM/DD/YYYY) 9. B Fore				
any		Usual Residence of Decedent	c. City, Town or Location	l				10d. Inside City Limits			
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th the Maryland 23a or 28n-f sho notified at once.	Director	3400 Sunnyvieu	Drive 5	Zip Code QAJ	09	109.	Citizen of What Co	untry?			
eath with items 23 ust be no	Funeral	11. Manital Status 1 Never Married 2 Married Armed Forces?	If Yes, spe		panic Origin? (Sp Mexican, Puerto		14. Race - Ame White, etc.	erican Indian, Black,			
MD 21215-0036 2 shouter the Maryland had Month the Maryland had Month Higgener with 72 hours after death with the Maryland by and Month Hygener had "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	اھ	3 Widowed 4 Divorced If Yes 2 X 15. Decedent's Education (Specify only highest grade comple	1 Yes	-	specify:	work done	Specify: B	lack			
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5-0036 led within 7: Hygiene. other than the Medical	Comple	17. Father's Name (First, Middle, Last)	Cour	rier		(First, Middle, Mai	iden Surname)	10			
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MD 2 d 2 shoul lth and M n 27 is m	To	19a. Informant's Name/Relationship (Type, Print) Kinclya Wilhoit-Webbly	0 -			Rural Route Number	er, City or Town, Sta	16, Zip Code)			
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imen men trant		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	MC+ropoli 122, Name a	nd Address		27-07	Alexano	Iria, VA Home, INC			
Balti permit. Departn Import injury		nelson & Street 2	814 F			Alexar					
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Vital hysician this cert	Be C	25. Was case referred to medical examiner? 1 V Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatient 3	DOA DOA	of Death (Check Other: Nursi		esidence 6 🗸 Ott	ner: Scene			
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Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		4 M Homicide determined (Specify) Local 29a. Certifier Check only 1 Certifying Physician: To the best of my ki		the time da	ate and place and		te) , Fort Washington (s) and manner as s				
To the Hos within 24 h To the Fur completely	edical	one) 2 Medical Examiner:On the basis of examinand manner stated.	nation and/or investigation, in	n my opinion	, death occurred	at the time, date ar	nd place, and due to	the cause(s)			
	Š	29b. Signature and title of certifier		29c. Licens O.C.I			29d. Date signed (March 19, 200)				
0 (4)		30. Name and address of person who completed cause of dea Ana Rubio MD. Assistant Medical Examin	, ,	t, Baltimo	ore, MD 2120	l. 1					
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State Registrar PHILIP

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FIELDS, M. A

32. gistrar's Signature

31. Date filed (Month, Day, Year) MAR 2 6 2007

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year **Physician** MARJORIE WAHLER ANNE 12:40 March 2007 US /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Baltinere Cluster If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 🛣 F Yrs. **Director** 579-20-9490 13, 1924 Washington, 82 DC Usual Residence of Decedent with the Marylend 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f ahow r notified at Morte ! 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "naturel", or iteme 23a or the Medical Examiner must be 3310 N. Leisure World Blvd. 20906 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ii. Pages 1 and 2 should be filed within 72 hours after riment of Heelth and Mental Hygiene. retri: if item 27 is marked other than "naturel; or ite hlury or other treumatic event, in Maricia Examina 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 SpecifyWhite 3 ☐Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John J. McGinnis Mary E. McRae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary C. Wahler/Daughter 1007 Covington Street, Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 25 Alexandria, Virginia 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if eny injury or once. Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licenses Francis Addess Collyins Funeral Home Inc. . Ken Skile 500 University Blvd, W, Silver Spring, MD 20901 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final gastroutestinal pladella **Physician** 412 LOURS disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner uenuc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner The law requires that the death certificate be executed ettending physicien and for use es the burial-transit Hierosclerotic disecur Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown peed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an pege 2 s autopsy performe certificate 1 Yes 2 No the Hospital or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2₽No 1-Inpatient 2 ER/Outpatient 3 DOA this Director: After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; → Natural 5 Pending investigation deeth. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hosping within 24 hours effer To the Funaral Dir 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 056399 Attellally 30. Name and address of person who completed cause of death (Item 23a) (Type: Print)

J.NAZARTN MD 301 ST. Paul ST. Baltinine, MD 21201 MD 31. Date filed (Month, Day, Year) State MAR 26 2007 Registrar

Cheryl Anne Whalen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

/ 1			
State of Maryla	ind / Department of F	lealth and	Mental Hygiene

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		- For State legistrar				Certific	cate of	Death			Reg	g. No.	200	1 1122
Physiciar fledical Examin	ı/ er	Decedent's Name (First, Mide	Cher	yl An		nalen					Date of Death	Day	Year	3. Time of Death 0529 hrs
	4	4a. Facility Name (if not instituti 6 High Street	on, give s	treet and nu	ımber)		4	b. City, Town, o Port Depo		of Death		4c. C	cil	1
Funeral Director	,	5. Social Security Number 019-54-4722	6. Sex	2 X F		In yrs. Iast bi 42	irthday) Yrs.	If Under 1 Ye Months Da			8. Date of Birth July 1	,	Foreig	thplace (State or gnMassachusetts puntry)
ow any	r	Usual Residence of Decedent 10a, State 10b, County	Cecil		10	c. City, Tow	n or Location	Port D	anogi	+-	-			10d Inside City Limits 1 X Yes 2 No
oith the Maryland 23a or 28a-f show any 2 notified at once.	ᄋᄔ	Maryland 0 10e. Street and Number 6 High Street		•				10f. Zip Code	219		10	g. Citizei	n of What Cou	ntry?
er death with th	ᇎ	11. Marital Status 1 Never Married 2	Married .	2. Was Dec Armed F 1 Yes Yes, Give Yes	orces?	rer in U.S.	If Ye	Decedent of Hes, specify Cub	lispanic Ori an, Mexicar	gin? (Spec n, Puerto Ri			1. Race - Amer White, etc.	ican Indian, Black, White
2 hours	Completed by	15. Decedent's Education (Sp Elementary/Secondary (0-12 Twelve Years	ecify only	r Dates:	de comple		Decedent during mo	's Usual Occup ost of working li 'E-5 Man Jationa	ation (Give e. DO NOT	kind of wor use retired Army	1)	16b.Kin Mary Nati	d of Business/ rland A onal G	Industry rmy uard
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Com	17. Father's Name (First, Middle		Sido	nio		- N			r's Name (F	irst, Middle, M ne Loui	aiden Su		race, MD e
MD 21; id 2 should the lith and Merican 27 is maraumatic even		19a. Informant's Name/Relation Marie-Elena Ca			sist			Address (Str Siles S				race	e, Mary	land 21078
or Hea		20a. Method of Disposition 1 Burial 2 X Cremation 4 Donation 5 Other S		Removal fi	rom State	crem	atory or oth	tion (Name of one place)		03/3	Date 1/07		cation - City or Chester	Town, State , Pennsylvania
Baltimo permit Page Department of Important: injury or ott		21. Signature of Funeral Service	e Cicense	1750	W.C	GV.	Le	ame and Addre A. Pa rryvill	tters e Ma	on &	d 2190	13-0	766	
Physician /Wedicar Examiner		23a. Part I. Enter the disease, of failure. List only one caus Immediate Cause (Final disease)	e on each e a. M	_{line.} ultiple Sh	narp Fo	rce Injuri	not enter th	e mode of dyin	g, such as	cardiac or re	espiratory arre	st, shock	k, or heart	Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1	the	1 Live	birth nant at tir	of pregnand	2 Fet	tal death	B Ectop	ic pregnanc	ey .		Date of deliver	y Day Year
P.O. E res that the c signed by the be detached	≥	Part II. Other significant cond	itions o	ontributing t	to death b	out not result	ting in the u	nderlying caus	e given in P	art I.				the cause of death?
Division of Vital Records, P. ra or Attending Physician: The law requires th rs after death. -al Director: After this certificate has been signe led in by the funeral director, page 2 should be de	Completed	<u> </u>						 :			24a. Was a autope perfor	sy m <u>ed</u> ?		utopsy findings available completion of cause of
tal Recician: The certificate	۲ ا	25. Was case referred to media	al					26.Pla	ce of Death	(Check on	ly one)			
Vita	o Be	examiner?	Ho	spital: 1	Inpatient	2 🗌 ER	/Outpatient	3 DOA	Other ₄				ce 6 🗸 Othe	er: Scene
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Divisi pital or Att ours after d neral Direct filled in by	Certification:	3 Suicide 6 Co	uld not be termined	2Be. Pla	ce of Inju	ry - At home i-Family <i>F</i>		et, factory, offic	e building, e		8f. Location (\$ or Town, S High Street,			ural Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire	Medical (29a. Certifier (Check only one) 2 Medical E	caminer: (n: To the be On the basis and manner	of exami	knowledge, on nation and/o	death occur or investigat	red at the time tion, in my opin	on, death o	occurred at	ue to the caus	and place	e, and due to t	he cause(s)
- = = = = = = = = = = = = = = = = = = =	ž	29b. Signature and title of cert	fier						onse numbe	r			ate signed (Me h 25, 2007	onth, Day, Year)
10		30. Name and address of pers Ana Rubio MD. A		mpleted car				Street, Balti	nore, MI	21201				
Sta Regist	ate rar	31 Date filed (Month, Day, Yea	2007	16° a	Registrar's	Signature	done	e e						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day MARCH 27 2007 1:35 ΑМ CHARLOTTE LOUISE WINTERS 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) WASHINGTON FAHRNEY-KEEDY HOME BOONSBORO If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1897 WASHINGTON, DC 1 ☐ M 2 💢 F Yrs. NOV. 10, 109 219-80-2510 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 🛛 No **BOONSBORO** MARYLAND WASHINGTON 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21713 U.S.A. 8507 MAPLEVILLE ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 No 1918-If Yes, Give Year or Dates: 1920 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: 3 X Widowed 4 □ Divorced WHITE 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) FEDERAL GOVERNMENT 12 clerk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) LOUISE BILD MACKALL COX BERRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7606 OLD NATIONAL PIKE, BOONSBORO, MARYLAND 21713 FUNERAL HOME RECORDS 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 2 Cremation 3 Removal from State 1 X BuriaL 5 ☐ Other (Specify) 13/30/2007 FREDERICK, MARYLAND OLIVET CEMETERY 4 Denation 22. Name and Address of Facility 21. Signature of F 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, scoom shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) neumori Due to (or as a consequence of): cna Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Year Month in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

or 28e-f show

'neturel', or Items 23a

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene Important: If item 27 is marked other than "neturel; or Item any injury or other traumatic event, Item Madical Exercises."

Baltimore, Maryland 21215-0036

other traumatic event, the Medical Examiner must be notified at

Funeral Director

Completed

Be

Examiner attending physician and for use as the burial-transit Completed by Physician/Medical detached f Be s after death.
I Director: After this ce
id in by the funeral dire 2 Certification:

2 Accident

3 Suicide

4 Thomicide

29b. Signature and title of certifier

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2€No

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Injury Natural 1 ☐ Yes 2 ☐ No

5 Pending investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

0060326

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hagerstown, Maryland Farid Murshed, M.D. 1126 Opal Court,

State Registrar

311-6+1

in 24 hours. the Funeral Directory filled in

within 2 To the the e

31. Date filed (Month, Day, Year) AR 28 2007

32. Pagistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No... 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Raymond Bertoli Zenone 5:30a 2007 20, Mar. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Severna Park Anne Arundel Genesis ElderCare If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days NY May 12, 1937 Director 116-26-3739 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No MD Anne Arundel Severna Park Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21146 USA 711 Dividing Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 □ No 1954 White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced 1957 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical Elementary/Secondary (0-12) College (1-4or 5+) other than State of Maryland Investigator 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be find Mental I Adelaide Bertoli Alexander Zenone is marked 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:3 Department of Health at Important: If item 27 is any injury or other trau Lois Zenone / wife 711 Dividing Road, Severna Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Mar. 21, 1 ☐ Buriat 2 X Cremation 3 ☐ Removal from State Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 22. Name and Address of Facility Barranco & Sons, 495 Gov. Ritchie P.A. Severna Park Funeral Ho Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 41 Cars **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence of Examiner The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) signed by the at the detached for 1 ☐ Yes 2 ☐ No 9 Dlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? page 2 s 1 Yes or Attending Physician: 25. Was case referred to edical examiner? Be 26. Place eath Check onl one Hospital: Other: 1 ☐ Yes 2 1 N 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: After 1 Datural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
rilled in by the ft 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a

To the Funeral C

completely filled i the Hospital 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29h. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

200 Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ahmer April 2:00 AM Physician .DU /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and nymber, Examiner hns Hopkins Bayview Medical Cente Baltimore N/AIf Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 □ M 2 🖾 F 1937 Dec. 6, Director West Virginia 212-34-3824 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medic | Examiner must be notified at 1 ☐ Yes 2 No Dundalk Baltimore Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21222 1951 Snyder Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be tiled within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Ite 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No Specify:White 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 9 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruby Coleman Wilbur Ruddlesden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6735 5th Avenue Dundalk, Maryland 21222 Sandra Chesnavage (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If it any injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4/12/2007 Oak Lawn Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 21222 7922 Wise Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 weeks PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** CANCER LVNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine COLON CANCER METASTATIC tor use as the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be d Completed by 2 No 3 Probably 4 Mnknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy perform 25. Was case referred to medical 26. Place of Death. Check onl. one director, To Be Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 ☐ Yes 2 No 2 ER/Outpatient this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Certification: 5 Pending investigation 1 Natural Injury 1 Tyes 2 Accident Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed P.O. Box 68760, Division or Vital Records, or Attending Physician: death.

Saltimore, Maryland 21215-0036

within 24 hours after death To the Funeral Director: completely filled in by the

Medical

State Registrar

29b. Signature and title of certifier

29a, Certifier (Check only

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE BALTIMORE SCHLENDORE Registrar's Signature

MEDILAL DOCTOR

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

29d, Date signed (Month, Dav. Year)

8,2007

21224

APRIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6:55 PM M April 3, 2007 Margaret G. Aldrich /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Medical Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Funeral Months 1 ☐ M 2 🂢 F Nov 21, 1918 88 475-01-4449 Japan Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 € No MD Director Prince George's Mitchellville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10450 Lottsford Road #3101 20721 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ▼No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white δ 3 Widowed 4 Divorced natural Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 4 math professor college other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event 20c8. 17. Father's Name (First, Middle, Last) Be George Glockler Ruby Clift 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10450 Lottsford Road #3101 Mitchellville, MD Thomas Aldrick/spouse 20721 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature Funeral ervice Licensee Honald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 und. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Java Cause)

Immediate (Final Java Cause) Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last (or as a consequence of) Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months?
1 2 Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown plnods Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2□No Division of Vital Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? 86 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 PER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manger of Death 28c. Injury at Work? Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Diractor: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified D58182 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cheverly And 20785 3001 Hospital 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** April 8. /Medical Charles George Brendel 2007 0930 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore If Under 1 Year If Under 24 Hrs. 307 Joplin Street Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days Hours 1**X** M 2□ F Months Min. Director Maryland 218-01-2519 12/22/1919 87 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ns 23a or 28a-f show must be notified at 1XYes 2 No Director Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a Funeral 307 Joplin Street 21224 United States Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No by Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: White "natural" Completed permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ARMCO Steel 8 Steel Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ို George John Brendel Bertha Mislak 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Brendel - Son <u> 1144 Gypsy Lane Baltimore, Maryland 21286</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation, 5 ☐ Other (Specify) 04/11/2007 Baltimore, Maryland Holy Rosary Cemetery 21. Signature Funeral Service Licensee 22. Name and Address of Facility David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Congestive heart **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ar oronam Sequentially list on citicals if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner My pertension or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No this certificate 2 1 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of Injury (Month, Day Year) 27. Man of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No Il Director: A 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospius. within 24 hours after de To the Funeral Direct 4 Homicide I 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

BBass, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

830 F. Monymont H. Rm 8068 Baltimore MD 21287

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Medi	Physici cal Exami	WI 11	1. Decedent's Name (First, Midd	dle,Last) Klein	Bust	2			2. Date of Deat Month	Day Year	3. Time of Death 0959 hrs
leui	cai Exami		Margaret 4a. Facility Name (if not instituti				City, Town, or	Location of Death	April 3, 20	4c. County of Dea	
			Baltimore Washingto				Glen Burnie	9		Anne Arunde	
	Funeral Director		5. Social Security Number		e (In yrs. last		If Under 1 Year Months Day			th (MM/DD/YYYY) 9. B	ign
	Jii dottoi	L	217-22-5882 Usual Residence of Decedent	1 M 2 X F	81	Yrs.			March	21,1926	ountry) MD
	r any		10a. State 10b. County			wn or Location				<u> </u>	10d. Inside City Limits
	Maryland 28a-f show any 1 at once.	ē		Arundel	Fernda						1 Yes 2 X No
	ith the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number] 1	Of. Zip Code			Og. Citizen of What Co	untry?
	Z15-UU30 be filed within 72 hours after death with the Maryland mal Hygiens man Hygiens when then whatural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once		9 Cromwell Avo	12. Was Decedent				spanic Origin? (S	pecify Yes or No-		erican Indian, Black,
	death or iten	Funeral	1 Never Married 2 X N	1 Yes 2	X No			n, Mexican, Puerto	Rican, etc.)	White, etc.	
	rs after rral",	<u>S</u>	Widowed 4 Di 15. Decedent's Education (Spe	vorced If Yes, Give Year or Dates:	nnleted\ 16		es 2 X No	specify:	work done	Specify: W	hite
	72 hour	eted	Elementary/Secondary (0-12)					e. DO NOT use ret		TOD. Tand of Edulicati	, mades y
900	5-UU36 lled within 72 hour Hygiene. d other than "natu	Completed	12			Homemak	er			Own Hom	e
7	Z1Z15-UU36 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Cc	17. Father's Name (First, Middle George E. K1					18.Mother's Name Viola J		Maiden Sumame)	
5	6 a 6 c		19a. Informant's Name/Relation			19b. Mailing Ad	ddress (Stree			nber, City or Town, Sta	te, Zip Code)
	ore, MID ss i and 2 sho of Health and If item 27 is her traumati		Mr. Robert W. 20a. Method of Disposition	Bush Sr./ Hu		9 Crom			en Burn:	ie MD 2106	
	Baltimore, MD 2 permit Pages I and 2 shou Department of Health and Mimportant: If item 27 is unjury or other traumatic		1 X Burial 2 Crematic	on 3 Removal from St	ate crei	matory or other	place)	Ap	ril 6,		
3	Baltimore permit Pages I Department of I Important: If		4 Donation 5 Other 5	Specify: e Licensee	GTe	n Haven	ne and Addres		007	Glen Burn Funeral H	
Ċ	Balt permit Departs Imports injury	7 1	Delema) SI	nick m	147			Avenue S	W Glen	Burnie, MD	
F	Physician /Medical		23a. Part I. Enter the disease, of failure. List only one cause	e on each line.		o not enter the r	mode of dying	, such as cardiac o	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
	Examiner		Immediate Cause (Final diseas or condition resulting in death)	e a Head and neck							Death
			Sequentially list conditions,	b							
		nin	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence of):						
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	execut an and al - trai	ical	UNPENDED	damended							
ç	ox 68/60, eath certificate be executed eath certificate be attending physician and for use as the burial - transi	Med	UNPENDED	23c. If yes, outco	me of pregnar	ncy			_	23d. Date of delive	•
Ġ	BOX 687 death certifice the attending p ed for use as th	cian/	23b. Was decedent pregnant in past 12 months?	I Live birti	t time of death	2 Fetal	death 3 (Specify)	Ectopic pregn	ancy	Month	Day Year
c	Box e death the atte	Physician/	1 Yes 2 No 9 U	nknown 9 Unknown		J Other	(Opcony)				
	P.O. Es that the d gned by the		Part II. Other significant cond	itions contributing to deal		-	erlying cause	given in Part I		obacco use contribute	o the cause of death?
	dS, Fequires	Completed by	Trypertensive athero		ilai uiseas		-	· · · · · · · · · · · · · · · · · · ·	24a. Was	an 24b. Were	autopsy findings available
	e cords, e law requir e has been s ge 2 should l	힐	l ——						autop perfor 1 🗸 Yes	rmed? death?	
•	ital Recician: The scertificate rector, page		25. Was case referred to medic	cal			26.Plac	e of Death (Check		2 No 1	163 2 160
	Division of Vital Records, Ital or Attending Physician: The law requir state feath. The above of the certificate has been seled in by the funeral director, page 2 should the lab of the funeral director, page 2 should the funeral director.	To Be	examiner? 1 Yes 2 No			R/Outpatient 3				Residence 6 Oth	er:
Ì	n of ding Ph h. After t		27. Manner of Death 1 Natural 5 Per	28a. Date of Inj (Month, Day) Apr 3, 2007	ury Year) 0	8b. Time of Inju 1915 hrs		ury at Work? Yes 2 ✔ No	Subject fell	how injury occurred	
	isior Attender death rector: by the	icati	2 Accident Inv	estigation 28e Place of I	njury - At hom	e, farm, street,					Rural Route Number, City
i	Divisior Hospital or Attenc 24 hours after death Funeral Director: stely filled in by the	Certification:	4 Homicide	uld not be ermined (Specify) Si	ngle Famil	у			or Town, S 9 Cromwell A	State) venue, Glen Burnie	MD
	Division of Vital Records, P.O. Box 68760, within the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		1	Physician: To the best of n	ny knowledge	death occurred	d at the time, on	date and place, and	d due to the caus	se(s) and manner as st and place, and due to	ated. the cause(s)
	To the within To the comple	Medical	one) 2 ✓ Medical Ex 29b. Signature and title of certifications of the control of the certification of the certif	and manner stated				se number		29d. Date signed (A	
			aux 2				O.C	.M.E.		April 4, 2007	
	10		30. Name and address of person						<u> </u>	<u> </u>	
	V			ssistant Medical Exa				ore, MD 2120	11		
		tate strar	31. Date filed (Month, Day, Year	2007 32. Registr	ar's Signature	Sparke	P				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 02, 2007 Year **Physician** James Edward Boonie APRIL 01:47 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 1**X** M 2□ F 70 210-28-3463 1936 Lewistown, PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Steuben Town of Campbell 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4790 Church Street 14821 IISA 12. Was Decedent Ever in U.S. Armed Forces? 1XI Yes 2 □ No If Yes, Give Year or Dates: 56 • -62 • Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: White à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **12** N/A Class A Machinist Glass Mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Stewart Boonie Nora Jane Cratzer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Rozina Court Owings Mills, MD 21117 James E. Boonie, Jr./Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Coopers Cemetery 20c. Location - City or Town, State April 10. 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Coopers Plains, NY 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Michael Flagle Part1. Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary Embolism disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Accident Vascular 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ★ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760. P.0. The law requires that or Vital Records, **Division**

Funeral

Director

28a-f show

If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me

Physician

/Medical

Examiner

attending physician and for use as the burial-transit the death certificate be executed

signed by the at d be detached for

certificate has birector, page 2 s

Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral To the

State

29b. Signature/ and title of certifier

determined

29c. License number 00061199

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) APril, 3, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles ST, Scite 209, Towson MD. 21204 ,6565 NorTh Jason 12

31. Date filed (Month, Day, Year) 0

4 Homicide

(Check only one)

29a, Certifier

Medical



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 200°7 8:22 AM James C. Bostain April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 10 Coach Lane Brooklyn If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country)
Ohio 8. Date of Birth (Month, Day, Year June 29, 1 5. Social Security Number 7. Age (In yrs. last birthday **Funeral X**□M 2□F 406-09-0303 85 Yrs Ĩ921 June Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 ☐ No Directo Brooklyn Maryland Anne Arundel 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 10 Coach Lane 21225 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 1944 If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced 1946 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Health and Mental Hygiene. Linguist Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James C. Bostain Ester White ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1692 Sterling, Virginia 20167 Lois Bostain, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: if ite any injury or of once. 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State Metro Crematory Inc. 04/09/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Meumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4 □ Pregnant at time of death signed by the a 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Musoschrotii Curchirurchur Disert 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has be rector, page 2 s autopsy perform 1∐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ eral Director: After th filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

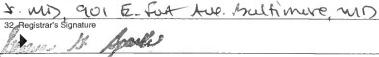
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) APR 1 0 2007

Horsell i Just

29b. Signature and title of certifier

Konert C.



Jr. WD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

aurt.

29c. License number

D39660

29d. Date signed (Month, Day, Year) April 9, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 5:54P Burgess Hilda 200 April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Randallstown Northwest Baltimore Hospital Center 8. Date of Birth (Month, Day, Year) 4/15/1922 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 T 6. Sex 7. Age (In yrs. last birthday) Days 1 ☐ M 2 🖫 F Hours 231-28-5719 84 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 TYes 2 THO Baltimore Gwynn Oak 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5410 Pembroke Avenue 21207 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. African-1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📶 No Specify. Specify: American 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Marvland Glass Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Collier Mamie Dillard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Lee Burgess/Son Longview Ct., Stewartstown, PA 17363 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date MD National Cem. 4/7/07 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie F/H P.A. of Balto. Co. 21. Surfure of Funeral Service Licer 9200 Liberty Rd., Randallstown, MD 21133 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anoxic brain injury disease or condition resulting in death) Due to (or as a consequence of): Pulseless electrical cardiac arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that little is to the cause). Multiple organ system

Due to (gras a consequence of): resulting in death) Last inflammator response syndrome Systemic IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown <u>lemporal</u> marasmus 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an End stage renal autopsy perform coronary artery disease 2 No HyperTension 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medical Examiner the burial-tran use as

Physician

/Medical

Examiner

Funeral Director

Completed by

Be 2 MD

Funeral

Director

should be filed within 72 hours after death with the Maryland nd Mental Hygiene.

marked other than "natural", or Items 23a or 28a-f show

3altimore, Maryland 21215-0036

item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

h and Mental H

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traum once.

attending physician signed by the a plnods page 2 s this

Physician/Medical Examiner

Be Completed by

Certification: To

requires that the death certificate be executed Physician: Attending Ь

Division or Vital Records, P.O. Box 68760, 4 hours after death.

Funeral Director: After this ely filled in by the funeral di To the Hospital o within 24 hours aft To the Funeral Di

State Registrar

Medical 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boston

3☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

6 ☐ Could not be

0

determined

D28462 Hospital Center Randallstown, Maryland

1 🕽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Northwest 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Division or Vital Records, P.O. Box 68760, Attending Hospital or within 24 hours aft

To the Funeral Di

completely filled in

5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

State Registrar

Medical

BOONYONG 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

15 conjunes

1 M-B THADA 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5356 REUTERSTUWN RD, BALTIMORE, MD 2121S

the

29c. License number

019823

29d. Date signed (Month, Day, Year)

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Il Records	The la ate has page 2	Completed						24a. Wa auto per 1∐ Yes
Vital	far, for,	Be (25. Was case referred to medical				26. Place of Dea	ath (Check only
	Physician: this certific al director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatient	3□ DOA	Other: 4 Nursing H	lome 5 Res
ivision or	Attending Phrdeath.ector: After the ythe funeral		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	28c	. Injury at Work? 1 ∐ Yes 2 ∐ No	28d. Describe
Divis	after Dire	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		At home, farm, stree becify)	t, factory, o	ffice	28f. Location City or To
	Hos 14 hc Fun Fun	Medical (hysician: To the best of my miner: On the basis of exam and manner stated.				
	To the within 2 To the comple	Me	29b. Signature and title of certifier	Kamal		_	icense number 39788	
	10		30. Name and address of person who SHALINI KAN	11	(Item 23a) (Type, Pr 2 N . HG	rfor	d Rd. N	nD 2
ı	Sta Registr		31. Date filed (Month, Day, Year) APR 1 0 20	32 Registrar's S		W		
Dŀ	IMH 17 Rev 1/20	001				DRIGIN	AL	

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		For	State o	f Maryla		partment of H		nd Mental H	/giene	2007	11232			
		State Registrar 1. Decedent's Name (First, Middle	- / oot)		C	ertificate of l	Jeath	2. Date of D	Reg. No	2001	3. Time of Death			
Physicia		William George Bo						April	8, Da	y 2007 Year	2:20 A M			
/Medic Examin	_	4a. Facility Name (If not institution		nber)		4b. City, Town, or			4c.	. County of Death				
	A	1708 Orlando Ro 5. Social Security Number	dQ 6. Sex	7. Age (In yrs	. last birthda	Parkville	If Under 24	Hrs. 8, Date of B	irth	Baltimore	place (State or Foreign			
Funeral Director		220-36-5355	1 X M 2□F	65	Yrs.	Months Days		Min. 12/6/1	941 941	Cor	more, MD			
and w		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or	Location					10d. Inside City Limits			
Maryl -f sho fied at	tor	MD Baltim	ore	P;	arkville	2					1 □ Yes 212 No			
th the or 28a e noti	Funeral Director	10e. Street and Number			21 144 177	10f. Zip Code			1	tizen of What Cou	intry?			
ath wi 23a lust b	ral	1708 Orlando Roa				21234				.S.A.				
ter de Items ner m	-une	11. Marital Status 1 ☐ Never Married 2 ☒ Marri	12. Was Dece Armed Fo ied 1 ☐ Yes	edent Ever in I rces? 2 X 1No	U.S. 1	 Was Decedent of H If Yes, specify Cuba 	ispanic Origir an, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)	lo-	 Race - Amer Black, White 				
72 hours after death with the Maryland naturalr, or Items 23a or 28a-f show dical Examiner must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or D	/e		1 □ Yes 2XX No	Specify:			Specify: Wh	ite			
72 hc "natul	eted		t's Education st grade completed)		16a. De	cedent's Usual Occup ve kind of work done of DO NOT use retired	ation during most o	of working	16b. K	ind of Business/li	ndustry			
within jiene. r than the Me	Completed	Elementary/Secondary (0-12)	College 4	-4or 5+)		ce Officer	"		Balt	timore Cit	y			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should bental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be	17. Father's Name (First, Middle,	Last)					s Name (First, Middle	e, Maiden	Surname)				
should nd Mei mark	ှင	George Bory 19a. Informant's Name/Relations	hip (Type. Print)		19b. Ma	ailing Address (Street		e Frye or Rural Route Num	ber, City o	or Town, State, Z	ip Code)			
and 2: alth ar 27 Is er trau		Marie Bory/ Wife			1708	3 Orlando Roa	ıd Park	ville, Mary	land 2	21234				
jes 1 a t of He If Item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐Removal from			position (Name of rematory or other place		Date		ocation - City or T				
tt. Pag rtmen rtant: njury		4 Donation 5 Other (S		Ca	edar Hi	11 Cemetery		11/2007		Burnie, I				
Depariment Impo		21. Signature or vulteral service	11. Signature of Juneral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road 21214											
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the dea	ath. Do not	enter the mode of dyin	g, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death			
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a/	140C	andi	al Jn	forct	100			Onser and Beaut			
Examiner			Due to	(or als a conse	and a	Arten	\ J /	discast	2					
P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a conse	equence of):		1							
executed executed in and rial-transit	Examiner	that initiated events resulting in death) Last	c	or as a conse	equence of):									
eath certificate be executed attending physician and for use as the burial-transit	_													
ertificating physe as th	Medi	IF FEMALE:												
The law requires that the death certificate be the has been signed by the attending physicia bage 2 should be detached for use as the bur	Physician/Medica	23b. Was decedent pregnant in the past 12 months?		come pf preg pirth 2 □ Fe nant at time of	tal death	3□Ectopic pregnancy 5□ Other (specify) _	,			23d. Date of deli Month	very Day Year			
w requires that the de been signed by the should be detached	hysid	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unkn											
es tha igned l	by P	Part II. Other significant conditi	A	,	esulting in the	e underlying cause giv	en in Part I.				the cause of death?			
requir	eted	righer	piden	9					Yes 2		bably 4 □Unknown			
The law	Completed							pe	opsy formed?	prior to o death?	topsy findings available ompletion of cause of			
	a)	25. Was case referred to medica	ıl				26. Place o	1 Yes of Death <i>(Check onl)</i>		o 1 □Yes	2 No			
di is	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)												
dlng P	ion:	27. Manner of Death 1 Natural 5 ☐ Pendir 2 ☐ Accident investi	19	of Injury th, Day Year)	28b. Time Injur	y Wor	yat k? Yes 2 ⊟ No	28d. Déscrib	e how inju	iry occurred				
Attending Physician: or death. ector: After this certification by the funeral director.	Certification:	2 Accident Investi 3 Suicide 6 Could 4 Homicide detern	not be 28e. Place	of injury - At	home, farm,	street, factory, office		28f. Location	(Street ar	nd Number or Ru	ral Route Number,			
iltal or irs afte iral Dii														
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		Examiner: On the b			eath occurred at the tir r investigation, in my o								
To th withir To th comp	Me	29b. Signature and title of certifie	1/2	1		29c. Licens	e number	8	29d. Da	ate signed (Month	n, Day, Year)			
<		Malini	Can	0/		135	110	<i>ن</i>	4	17/0	/			
10		30. Name and address of person SHALINI K	who completed cause	se of death (It	em 23a) (Tyr	De Print) ord	Rd.	MD &	123	34.				
Sta	te	31. Date filed (Month, Day, Year,) 32. F	Registrar's Sig										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nor 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day CHARLES CHEEVES 3:45 AM APRIL 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FUTURECARE - OLD COURT RANDALLSTOWN BALTIMORE 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**X** M 2□ F 216-40-1606 63 01/26/1944 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A MD BALTIMORE CITY 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1700 EDMONDSON AVE., APT. 001 21223 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo f Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed Wivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE SUPERVISOR CLEANING COMPANY 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES SLAUGHTER JANE HARRINGTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ETHEL BROWN / SISTER 2015 W. SARATOGA ST., BALTIMORE, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT. ZION CEMETERY 4/14/07 LANSDOWNE, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral Service Licenses 4600 LIBERTY HEIGHTS AVE, BALTIMORE, the Enter the disease, or complications that caused the de lock, or head failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final dise or condition resulting in death) arcenoma 0 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 1∐ Yes 2□ No

Physician /Medical Examiner

Physician

*/Medical

Examiner

Funeral

Director

23a or 28a-f show

or,

natural"

Department of Health and Mental Hygis Important: If Item 27 Is marked other i any Injury or other traumatic event, <u>tt</u> once.

Examiner must be notified at

Director

Funeral

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Completed

Be

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with the Maryland

r death

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Examine Physician/Medical as asn ō detached þ Completed ate has page 2 s Be P this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral Medical Certification:

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Hospital or Attending Physician

To the

State Registrar

29a. Certifier

(Check only one)

29b. Signature and fittle of certifier

29c. License number

1 Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

20, Crossroads Drive Sciete 101,

and manner stated.

30. Name and address of person who completed calle of death (Item 23a) (Type, Print) Kawala lahoora

32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 1 0 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Nola Calhoun 2007 2345 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Montgomery County General Hospital 01nev If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 💢 F 233-64-3543 96 Director Feb 15 1911 Kentucky Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County G1enwood 1 ☐ Yes 2 🕅 No Md Howard Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2954 Washington Road 21738 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: white 2 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bess Hall Fred Kitchen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Weinroth (daughter) P.O. Box 22, Glenwood, MD 21738 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-10-07 Ressurection Acres Cem. Baltimore, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service License Parguspaiger Serbert P.O Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Myocar /Medical Due to (or as a consequence of): Examiner 9,0 0 Rouge Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 → 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 No 1☐ Yes Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Injury Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral L 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier unt) BC 108 2039 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Matthew

APR 1 0

2007

31. Date filed (Month, Day, Year)

onolly

egistrar's Signature

Montgomery Country General, Olney, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3:35 P. M William Woodrow Cusick April 06, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore County Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 19,1927 Baltimore, MD. 1 1 M 2 □ F Months Days Hours Min. 79 218-22-4829 August Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County Show Items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore County Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 6 Roundridge Road U.S.A. by Funeral permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ZYes 2 □ No If Yes, Give W•W•II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 ò Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" er than "natur the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore Gas Electric Elementary/Secondary (0-12) College (1-4or 5+) Pole Inspector n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 Is marked or traumatic ever Edith Virginia Willey Joseph Houston Cusick 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timonium, Maryland 6 Roundridge Road 21093 27 Mrs. E. Lorraine Cusick (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If It any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 80 Evans Funeral Chapel Forest Hill, Maryland 4 Donation 5 Dother (Specify) Peaceful Alternatives Funeral&Cremation Ctr.,P.A 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee 23a. Part. This rethe disease, or complicate his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sinck, or heart failure. List only one cause on each line. Immediate Cause (Final months **Physician** 17 4 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy pertormed? Yes 2 No or Attending Physician: rector. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA this (27. Manner of Death 1 ☑ Natural 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Affer 5 Pending investigation Injury (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 <mark>F certifying Physician:</mark> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) N. Charles St. Balto-Md Zc204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

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			For State Registrar		State of M	arylan		artment rtificate			d Menta		ene 1. No. 2 0 0	1	112	36
#	Physici	an	1. Decedent's Name Elizabet		,							te of Death onth ri1	Day 20	ear 107	3. Time of De 23:20	
	/Medic Examin Funeral Director	er		washing	ve street and number) gton Medica Sex 1□M 2\ndex 5 F	al Ce	last birthday)	4b. City, Glen If Under Months	Bu	If Under 24	Hrs. 8 Da	te of Birth o <i>nth, Day,</i>) rch 30	4c. County of Anne A	rund		Foreign
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	7548 O1d 11. Marital Status 1 □ Never Marr 3 🛣 Widowed	ied 2□ Married	h Road 12. Was Decedent Armed Forces' 1 □ Yes 2 1 If Yes, Give Year or Dates:	?				ispanic Origin an, Mexican, F Specify:	n? (Specify Youerto Rican,		S . A . 14. Race - Black, Specify:	Americar White, et	C.	
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Maryland	nd 2 should lith and Me 27 is mark r traumatic	은	19a. Informant's Na	ame/Relationship	(Type Print)	r					or Rural Roui		City or Town, St	ate, Zip (Pode)	
Baltimore,	Pages 1 ar tment of Hea tant: If item jury or other		20a. Method of Disp 1 ☐ Burial 2 4 ☐ Donation	position	☐Removal from State	20b. F	Place of Disponentery, cres	osition (Name matory or o	ne of therplac emat	ce) A	pril 5 2007	20	oc. Location - Ci Steven	svil	le, MD	
Ball	permit Depari Impori any In		21. Signature of	we		-	01411 1	Seco	nd A		SW G1e	n BUr	Funeral	210	61	
	Physician /Medical Examiner		23a. Part 1. Enter t shock, or hea Immediate Cause disease or conditio resulting in death)	art failure. List only (Final	nplications that cause y one cause on each a Due to (or as	Spi	ratu	ter the mod	e of dyn)	ardiac or resp	4	st,		Approximate nterval Betwe Onset and De	een ath
68760,	- Mag	cal Examiner	Sequentially list co cause. Enter Unde Cause (Disease or that initiated events resulting in death)	erlying injury	b. Due to (or as											
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or Vital Record		Completed										4a. Was an autopsy perform □ Yes 2	ed? pri	or to com ath?	sy findings av pletion of cau	railable use of
Division or Vita	or Attending Physician: The siter death. Director: After this certificate in by the funeral director, pag	Certification: To Be	25. Was case refeexaminer? 1 Yes 2 27. Manner of Dea 1 Natural 2 Accident 3 Suicide 4 Homicide	No	be 28e. Place of in	jury ay Year)	28b. Time of Injury ome, farm, st	of 2	28c. Inju Wo	ner: 4 ☐ Nurs	28d. E	5 ☐ Resider Describe hov	nce 6 □Other v injury occurred	1		er,
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	Sta Regist		31. Date filed (Moi	APR 10	2007 32 Regis	trar's Signa	ature A	whi		-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 15:21P M Cunningham 8 2007 John Joseph April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, 9. Birthplace Country) (State or Foreign **Funeral** 1 X M 2 □ F 212-12-7652 87 Oct. 12,1919 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event the Martin 1. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 21 No Anne Arundel Director Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 6th Street 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed by 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Police Department 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peter K. Cunningham Barbara Mary Zant 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 469 Retford Drive Severna Park, MD 21146 Mr. Gregory Cunningham/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 12. 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Vet. Cem. 2007 4 Donation 5 Other (Specify) Crownsville,MD 22. Name and Address of Facility Singleton Funeral Home, P.A. 21. Signature of aner Service Licensee Second Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Immediate Cause (Final **Dhysician** resulting in death) edical Due to (or as a consequence of): aminer Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as the use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð pe 1 Tes 2 □ **N**o 3 Probably 4 ☐Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1. Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural in 24 hours after death.

In Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician, To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

within 24 hor To the Fune completely fi the 2 O_{\prime}

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Pfint)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

A I V A CI

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			Please 1 - State Amend #12, per Registrar	State of M FH, g866, 4/1	nt in Bla arvland 0/07 11	ack In Depa Cea	delible Ink artment of I rtificate of	. Ensure A Health and Death	All Copies Mental Hy	Are giene	Legible.	7
**	Physici /Medic		negistrar Decedent's Name (First, Middle, L DAVID				OHEN	Deam	2. Date of De Month			3. Time of Death 6:13 P
	Examir Funeral Director	ner	5. Social Security Number 6. 218-22-7024	OURT	ge (In yrs. las	t birthday) Yrs.	TIMON If Under 1 Year Months Days			th ly, Year)	9 Bir	th MORE thplace (State or Foreign unitry) MD
	e Maryland a-f show tifled at	ctor	Usual Residence of Decedent 10a. State 10b. County MD BALTI	MORE	10c. City, 1	Town or Lo						10d. Inside City Limits
	ath with th	Funeral Director	7 FIELDSPRING (OURT			10f. Zip Code 2109				U.S.	Α.
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: I fleen Z1 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1 M Yes & H If Yes, Give Year or Dates:	?		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Sean, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.))•	14. Race - Ame Black, Whit Specify:	
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and 2	should be filed and Mental Hygis s marked other umatic event, ti	To Be Co	17. Father's Name (<i>First, Middle, La</i>	st)			ESIDENT COHEN	18. Mother's Nar	me (First, Middle	, Maider	,	HAMBURGER
Σ	1 and 2 shou Health and M em 27 is mar other traumat	-	19a. Informant's Name/Relationship MARY COHEN / WI			19b. Mailii	ng Address (Street	and Number or R		-	or Town, State, .	
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Ball	permit. Page Department of Important; If any Injury or once,		21. Signature of Funeral Service Lice McH Lev -	ensee		1	2. Name and Address 8900 REIS	3	OL LEVIN ROAD -	ISON PIKI	& BROS. ESVILLE	, MD 21208
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	cate be executed physician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequer							
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סו אוומו	Physician: r this certifica ral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpati		∛Outpatier	IL 3 DOA	ner: 4 Nursing H	ath <i>(Check only c</i> Home 5 Resi	dence		ecify)
=	Ing Affel	Certification:	27. Manner of Death 1.	be 28e. Place of in	ay Year)	8b. Time o Injury e, farm, str	Wo	ryat rk?]Yes 2 ☐ No	28d. Describe 28f. Location (City or To	Street a	nd Number or R	ural Route Number,
2	To the Hospital or Attend within 24 hours after death. To the Funeral Director: A completely filled in by the fr	Medical Cert	29a. Certifier Certifying	Physician: To the best aminer: On the basis of	of my knowle	edge, deat n and/or in	n occurred at the t	ime, date and plac	e, and due to the	cause(s) and manner a	s stated. e to the cause(s)
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16	ó.		30. Name and address of person wh	o completed cause of	death (Item 23	3a) (Type,	Print) DAV	D McGu	unis, Min		1-1-1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Of Maryland /	Certificate of Death	Reg.	2007	1123
Physici		Decedent's Name (First, Middle, Last) CHARLES A. CHERIGO			Day Year , 2007	3. Time of Death 8:20 A.M
/Medic Examir	-2	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	0.20 1111
		1608 ABERDEEN ROAD 5. Social Security Number 6. Sex 7. Age (In yrs. last by the second security Number 1. Age (In yrs. last by the second seco	LOCH RAVEN VILLAC		BALTIMOF	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to 215–09–3501 92 Usual Residence of Decedent	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 9/26/191	ar) Sinnp Coun MAR	lace (State or Foreig try) LAND
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Ba-f s	Director	MD BALTIMORE LOCK	H RAVEN VILLAGE			1 □ Yes 2√ N
with th	Dire	10e. Street and Number	10f. Zip Code		Citizen of What Coun	try?
ns 23	Funeral	1608 ABERDEEN ROAD 11. Marital Status 12. Was Decedent Ever in U.S.	21234		USA 14. Race - America	an Indian.
be filed within 72 hours after death with the Maryland that Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fun	1 □ Never Married 2 ▼ Married 1 ▼ Yes 2 □ No 1 ▼ Yes 3 □ Widowed 4 □ Divorced	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White, e	etc.
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other ent, tl	Be C	17. Father's Name (First, Middle, Last)		(First, Middle, Maid		
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2 sho l and l is ma			9b. Mailing Address (Street and Number or Run	al Route Number, Cit	ty or Town, State, Zip	Code)
s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		MICHAEL C. CHERIGO/SON 20a. Method of Disposition 20b. Place	3039 N. CALVERT STREEY of Disposition (Name of		TIMORE, MD. Location - City or To	21218_
00 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MOST	tery, crematory or other place) HOLY REDEEMER		ALTIMORE,_I	
permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licensee		JOHNSON	FUNERAL HO	ME, P.A.
		23a, Pan1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.			1V, 11D 2.12	Approximate Interval Between
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- 100	Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence				
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s beer shou	Completed			24a. Was an	24b. Were autor	osy findings availal
	lmo			autopsy performed 1∐ Yes 2⊠	Prior to con death? No 1 ☐ Yes	npletion of cause o 2⊠No
iclan: Th certificate ector, pag	Be (25. Was case referred to medical examiner?	26. Place of Death			
Physician: r this certific ral director,	2		Outpatient 3 DOA Other: 4 Nursing Ho D. Time of 28c. Injury at	me 5 Residence 28d. Describe how in	e 6 □Other (Specify)
Attending r death. ector: After by the fune	tion	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	o. Time of 28c. Injury at 1	Log. Describe flow ii	njury occurred	
I or Atter after dea Director	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rura tate)	Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled and manner stated.				
To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, i	Day, Year)
1		Thomas SW & 500 M	D40277		April 6,	2007
1		30. Name and address of person who completed cause of death (Item 23a	a) (Type, Print)	,		į.
<u>U</u>		THOMAS S. WILSON 5601 LOCH RAVEN 31. Date filed (Month, Day, Year) 32. Registrar's Signature		21239		
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		State of Maryland / Department of Healt		ygiene
		1 - State Certificate of Dea	th	Reg. No. 2001
Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of D	Death Day Year 3. Time of Death
/Medic	al	Dessie Lox	ion of Dooth	4 2007 345 P M
Examin	er	4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Locat 4b, City, Town, or Locat	1	Baltimare
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Un	nder 24 Hrs. 8. Date of B	9. Birthplace (State or Foreign
Director		2/3·20·8302 1 M 7 83 Yrs. Months Days Hou	ars Min. (Month, C	3.1923 Mary and
pus		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Maryle f shored at	ō			1 ☐ Yes 2 No
the 7	Director	MD Baltimore handallstan 10e. Street and Number 10f. Zip Code	7	10g. Citizen of What Country?
h with	al D	3715 Flhanah Place 2/13	3	USA
Lat y fair to Z I Z I J COOOO 2 should be filed within 72 hours after death with the Maryland and Mential Hygiene. Is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Armed Forces? 13. Was Decedent of Hispanic If Yes, specify Cuban, Me.	o Origin? (Specify Yes or Nixican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
s afte	by F.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 M No If Yes, Give 1 ☐ Yes 2 M No Spe 3 ☑ Wildowed 4 ☐ Divorced Year or Dates:	ecify:	Specify:
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c, wan yname 2 to 1 to 1 and 2 should be filed within the with and Mental Hygiene. To 1s marked other than the traumatic event, the M			A	hber, City or Town, State, Zip Code)
ten 27	- 1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	stan mo 91133 20c. Location - City or Town, State
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show appring injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensae 22. Name and Address of F	acility Vaughn C.	Chandallstein, MD
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		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cruse on each line.	h as cardiac or respiratory	arrest, Approximate Interval Between Onset and Death
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The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	by P		Part I. 23e. Die	d tobacco use contribute to the cause of death?
faw requires that see as been signed as been signed as the could be considered.	ted		1	☐ Yes 2☐ No 3☐ Probably 4 ☑ Unknown
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has a completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, da (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinior and manner stated.	ate and place, and due to the n, death occurred at the tim	he cause(s) and manner as stated. ne, date and place, and due to the cause(s)
o the vithin o the	Med	29b. Signature and title of certifier / 29c. License num	nber	29d. Date signed (Month, Day, Year)
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29b. Signature and title of certifier O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	P.O.			/n
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07-02560

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year CURETON APRIL ALLEN 2007 05 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospita Baltimore Secours 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F -36-332 Hours South Carolina Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside Çity Limits r 28a-f show notified at 10a. State 10b. County 1 Dres 2 No Director Maryland 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be r 2519 Haca 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 ☐ Merried altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: à 3 Widowed 4 Delvorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Mail Gerk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be pretta unknown ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route, Number, City or Town, State, Zip Code) Haca 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Deremation 3 □Removal from State Metro 4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral Service Licen 22. Name and Address of Facility proximate nterval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ACYTE RENA2 /Medical Due to (or as a consequence of): **Examiner** PANCO21TIS CLOSTRIDIUM DIFFICIZE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed ARTERIOSCLER and physician al s the burial-t Box 68760, Physician/Medical CHRONIC D13 EA the ! as the attending IE FEMALE nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) P.O. I 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 🗌 Yes 2 No 3 Probably 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificate has f 2 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 1 npatient 3□ DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 1 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Sarrol D 23300

State Registrar

31. Date filed (Month, Day, Year)

APR 1. 0 2007

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OFLIGINAL

130N

2000 W. BAZTO

SELONES

BAZTO MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	-	partment of He		ental Hygie	2001	11243
Physician			1. Decedent's Name (First, Middle,	Last)	Darr	110	2. Date of Death Month	Day A Year	3. Time of Death	
ł	/Medic Examin		4a. Facility Name (If not institution, give street and number) HEron Point			4b. City, Town, or Lo	City, Town, or Location of Death Ac. County of Death Lestertown Kent			h
	Funeral Director		217-18-6318	5. Sex 7. Age 1	(In yrs. last birthda 89 Yrs.) If Under 1 Year I	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Nay 20, 19	aar) Co	hplace (State or Foreign untry) EW York
	vith the Maryland or 28a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Ker		10c. City, Town or	Location restertow				10d. Inside City Limits 12 Yes 2 □ No
		Funeral Director	100. Street and Number 501 East Campus Avenue			10f. Zip Code		10g.	. Citizen of What Co	ountry?
	death was 23	neral	11. Marital Status	12. Was Decedent E		21 G 2 I. Was Decedent of Hisp If Yes, specify Cuban,		cify Yes or No-	14. Race - Ame	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If tiem 27 is marked other then "natural, or items 23a or 28a-f show eny injury or other traumatic event, it is Marilcal Examinar must be notified a ORCE.	þ	1 Never Married 2 Marne 3 Widowed 4 Divorced	Armed Forces? d 1 Yes 2 No If Yes, Give Year or Dates:		4.4	Specify:	tican, etc.)	Black, Whit	hite
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Maryland			19a. Informant's Name/Relationshi	A		iling Address (Street and				
			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		20b. Place of Dis	position (Name of rematory or other place)	Da		MD 2 c. Location - City or	
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Ba			21. Signature or Funeral Service Licensee 22. Name and Address of Facility . Anatomy Gifts Registry 7522 Connelley Drive Suite P. Hanever, MD 21076							
	Physician /Medical Examiner		23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final	nly one cause on each line	9.	CALL AND ST				Approximate Interval Between Onset and Death
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e	ocuted and transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events c.							
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.O. Box 68		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐No 9 ☐ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death	B Ectopic pregnancy Country (specify)		23d. Date of delivery Month Day Year		
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n of		on: To	27. Manner of Death	28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred						City
Division	Hospital or Atten 14 hours after deal Funerel Director: tely filled in by the	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	ation at be	ry - At home, farm, (Specify)	M 1 ☐ Yestreet, factory, office				
		edical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
)	To the within 2 To the comple	Me	29b. Signature and title of certifier	Morre	mo	29c. License r	0415	87	Date signed (Month	7
	١		30. Name and address of person we Helen A	Noble mis	122		Suite	5 Ch	estertou	n, MD
		State 31. Date filed (Month, Day, Year) 32. Rehistrar's Signature agistrar APR 1 0 2007								

		1- State of Maryla	-	rtment of Health a tificate of Death	nd Mental Hy	/giene Reg. No. 2	10.7	11241	
Physicia /Medic		Decedent's Name (First, Middle, Last) Beverly DeFranco			2. Date of D Month April		7 Year	3. Time of Death 2:45 pm	
Examin		4a. Facility Name (If not institution, give street and number) Casey House Montgomery Hospice	9	4b. City, Town, or Location of Rockville		,	nty of Death Montgomery		
Funeral Director		485-24-3674 1□M 2 □ 79	rs. last birthday) Yrs.	If Under 1 Year If Under 2 Months Days Hours	4 Hrs. 8. Date of B Min. 08/25/	irth 1927	9. Birthpla Counti	ace (State or Foreign ry) IA	
Maryland I-f show fied at	tor	Usual Residence of Decedent 10a. State 10b. County MOntgomery 10c. 0	City, Town or Lo	Onley			10	d. Inside City Limits 1 XYes 2 □ No	
h with the	al Director	10e Street and Number 17401 Moss Side Lane	,	10f. Zip Code 20832		10g. Citizen of	What Count	ry?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 1. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Vas Decedent of Hispanic Orig f Yes, specify Cuban, Mexican, ☐ Yes 2 No Specify:	in? (Specify Yes or N Puerto Rican, etc.)	o- 14. Rad Bla Specif	ce - America ck, White, e y: Whi	tc.	
within 72 hc ene. than "natu ne Medical		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Deced (Give : life. L	lent's Usual Occupation kind of work done during most O NOT use retired) Homemaker	of working	16b. Kind of B	usiness/Indo		
ld be filed a ental Hygid ked other ic event, the		17. Father's Name (First, Middle, Last) Leroy Hummel		18. Mother	's Name (First, Middle th Sherman	e, Maiden Surnar			
and 2 shou alth and M 27 is mar er traumat		19a, Informant's Name/Relationship (Type. Print) Jay DeFranco / Son	19b. Mailin 174	g Address (Street and Number 01 Moss Side I	or Rural Route Num Lane, Onle	ber, City or Town Y MD 20	State Zip (Code)	
Pages 1 s ment of He ant: If Item lury or othe			ount Hop	sition (Name of natory or other place) De Cemetery Apr		_	ı, IL	vn, State	
permit. Depart Import any Inj		21. Signature of Funeral Service Licensee	22 C 1	Name and Address of Facility Charles L. Stev 501 East Fort	vens Funer Avenue, B	al Home altimore	Inc.	21230	
Physician /Medicale pe executed /Medicale Examiner as the burial-transit	sal Examiner	23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, line and because the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lower Cause (Disease or injury that initiated events resulting in death) Last	nt Pneum equence of: On's Dis	onia	ardiac or respiratory.	arrest,		Approximate Interval Between Onset and Death	
ath cer titendir or use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome pf pregnant at time of the pregnant at	etai death 3	lEctopic pregnancy Other (specify)		,	te of deliver	y Day Year	
quires that the de	þ	Tarth. Other significant containoung to death but not resulting in the didentifying cause given in Part i.							
The law require ate has been sit page 2 should t	Completed				24a. Wa: auto peri 1 Yes	opsy formed?	Were autop prior to com death? 1 ☐ Yes 2	sy findings available pletion of cause of	
nysician: ils certific director,	To Be	25. Was case referred to medical examiner? 1							
Attending Physician: The sr death. rector: After this certificate he by the funeral director, page by the funeral director, page	Certification:	27. Manner of Death 1 X Natural 2 Accident 3 Suicide 6 Could not be		28c. Injury at Work? M 1 ☐ Yes 2 ☐ N	28d. Describe	how injury occur	red		
ital or Al irs after d ral Direc lled in by		4 Homicide determined building, etc. (Specify)							
To the Hospital or within 24 hours afte To the Funeral Dil completely filled in	Medical	29a. Certifier (Check only one) Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
vith Tot	Σ	29b. Signature and title of certifier Rypttie M. Hilliam		29c. License number H0058C		29d. Date signe	07	ay, Year)	
10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia M. Williams, M.D. 6001 Muncaster Mill Road, Rockville, MD 20855							
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Sig	nature	E Company of the Comp					
IMH 17 Roy 1/2/	01								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 3:15 AM APRIL 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Futurecare Cherrywood Baltimore Reisterstown If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 🕱 F Director 218-12-0194 84 May 18, 1922 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 ▼No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1229 Kimberly Lane 21061 US A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. ģ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 d 2 should be filed with and Mental Hygier 7 is marked other the Westinghouse Buyer permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Gossage Josephine Twining ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James M. Bloom, Jr./ Nephew 518 Cockeys Mill Rd., Reisterstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 XOther (SpecifyEntombment Evergreen Mem Gardens 4/17/2007 Finksburg, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 8728 Liberty Rd., Randallstown, MD Lemmer Trand 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CEREBRO VASCULAR ACCIDENT Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to for an a consequence of: Examiner it any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of): Box 68760 physician pe Physician/Medical as the t attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Voar 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a detached f P.0. 9□Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 | Yes 2 | No 3 | Probably 4 | Honknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has page 2 s 1□ Yes 2⊡-No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 46 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of cortifie 29c. License number 29d. Date signed (Month, Day, Year) 2 M.D APRIL 5 2007 DS1722 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1838 GREENE TREE ROAD \$300 PILESVILLE MP 21208 LEONARD RICHARDSON M.D. 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

APR 1 0

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AManth. Physician 2007 William Joseph DePaola, Sr. /Medical Facility Name (If not institution, give street and n County of Death Examiner 5. Social Security Number loseda le 19 vare imore Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 3, Birthplace (State or Foreign Country) **Funeral** Sex 1XIM 2□F Days Hours Months Min 76 1930 212-28-1373 Mary land Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 1 ☐ Yes 2 No Director Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U. S. A. 1 Silver Hill Court 21128 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. 1 M Yes 2 No 1950 − If Yes, Give Year or Dates: 1951 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by Pages 1 and 2 should be filed within 72 hours and to Health and Mental Hygiene.
int: If item 27 is marked other than "natural"; 3 Widowed 4 Divorced 1951 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Baltimore Elementary/Secondary (0-12) College (1-4or 5+) 12 Police Officer City Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Victor E. DePaola Edna Cross ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silver Hill Court, Perry Hall, Maryland 21128 Beatrice M. DePaola (Wife) permit. Pages 1 and Department of Healt important: If item 2 any injury or other once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place St. Joseph Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/12/2007 | Baltimore, Maryland 21. Signature of Funeral Service Licensee-22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Road, Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Heu disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Wonknown peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate 2 No or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2∐ No 2 ER/Outpatient 1 Inpatient 3□ D0A funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: No the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On/the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and major major stated. (Check only one)

within 24 hours after death To the Funeral Director: completely

> State Registrar

29b. Signature and titl

30. Name and address

Derwin

ADD 1 A

31. Date filed (Month, Day, Year)

of certifie

2007

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as who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

9000

29c. License number

Square Prive, Baltimore, MD. 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician 200 Walter Herman Dircks /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner CUSE 41 +Imor Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Date of Birth (Month, Day, Year) **Funeral** Hours 1 M 2 □ F Months Days 1929 212-26-6582 Aug. 23 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 ☐ Yes 2X No Director Baltimore White Marsh Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U. S. A. 21162 9704 Gaylord Street Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No 1947—
If Yes, Give Year or Dates: 1951 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Company 12 Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Dietz Walther Dircks ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9704 Gaylord St., White Marsh, Maryland 21162 Patricia Dircks (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 04/11/2007 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySchimunek Funeral Homes 21. Signature of Puneral Service Licenses 9705 Belair Road, Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest prock, or heart failure. List only one cause on pean line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease or irjury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 □Ectopic pregnancy Day in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

the death certificate be executed Division or Vital Records, P.O. Box 68760, ed by the detached been signed by should be detacl The law requires has page 2: certificate this funeral After or Attending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu death.

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attending physician

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ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other transmitted.

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State Registrar 29b. Signatu

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30. Name and address of person who d

31. Date filed (Morith, Day, Year)

DHMH 17 Rev 1/2001

2960 **ORIGINAL**

mpleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

9000 Frankli

29c. License number

D0060560

29d. Date signed (Month, Day, Year)

Sq. Price Britimore Md. 212

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day RAYMOND DINKIN APRIL 3, 2007 7:35P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1**X** M 2□ F 122-14-0755 81 06/16/1925 NY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Y Yes 2 □ No VA N/A FREDERICKSBURG 10g. Citizen of What Country? 10e. Street and Number 7 FAIRBANKS COURT 22405 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No WHITE Specify. Specify: 3 Nidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INTERNATIONAL TRADE SPECIALIST US GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DINKIN RUTH KALMANOV I CH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GARRY DINKIN / SON _22405 FREDERICKSBURG. FAIRBANKS COURT, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW REISTERSTOWN, MD 04/08/2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lices 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 23a. Party. Entey the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pproxima e interpretations. tervar Between nset and Death Immediate Cause (Final disease or condition resulting in death) Due to for as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year)

Physician /Medical Examiner

Department of H Important: If ite any injury or ot once,

Physician

/Medical

Examiner

Funeral

Director

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rai", or items 23a or 28a-f shov Examiner must be notified at

r than "natural", or the Medical Examin

nt of Health and Mental Hygiene.

If item 27 is marked other than or other traumatic event, the Me

filed within 72 hours after

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Pages 1

Baltimore, Maryland 21215-0036

Director

Funeral

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The law requires that the death certificate be executed

or Attending Physician:

Division or Vital Records, P.O. Box 68760,

Physician/Medical Completed by Be P

Examiner

Hospital To the I

within 24 hours after death.

To the Funeral Director: /

Registrar

Medical Certification: 4 ☐ Homicide determined T Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

1 Natural

2 Accident

3 ☐ Suicide

727569

1 □ Yes 2 □ No

29d. Date signed (Month, Day, Year) PN 21208

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of pers who completed hus f d ath (Item 23a) (Type, Print) leman

5 Pending investigation

6 ☐ Could not be

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** NELLIE APRIL A M ENGLE 0821 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner RANDAUSTOWN
If Under 1 Year | If Under 24 Hrs. BALTIMORE NURTH MEST HUS PITAL Date of Birth (Month, Day, Year) 5/23/1919 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Hours 1 □ M 2 🗓 F 87 MD 216-03-6188 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner misst han activated and injury or other traumatic event, the Medical Examiner misst hand a contract has a contract and any injury or other traumatic event, the Medical Examiner misst hand a contract has a contract and a contract hand and a contract hand a contra 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No MD Baltimore Director Owings Mills 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 6 Birkenhead Court Funeral 21117 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Africanģ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Engle Etta Engle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James T. Jones/ Nephew Birkenhead Ct., Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro 4/9/07 Crematory Baltimore. MD 22. Name and Address of Facility Wylie F/H P.A. of Balto. Co. of Funeral Service Licenses 9200 Liberty Rd., Randallstown, 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** epsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. (List of the property of that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending physi IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Day Year 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No autopsy page perform certificate 1∐ Yes 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√(No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A filled in by the fo 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year)

ДА

State Registrar 31. Date filed (Month, Day, Year)

WATSON

DEBURAH



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0059736

HOSPITAL

COURT

NOLTHWEST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 17,18 per fh/8866 4-10-07 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 3:12 8 10 ROTHY 2007 */Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner BAUTIMOKE, MP MERCY BALTO MED C177 Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 19,1928 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔽 F 181-22-1149 78 Pennsylvania Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f shov notified at 1XYes 2 No PA Philadelphia Director Philadelphia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 'natural", or items 23a or dical Examiner must be 19154 United States 3814 Oakhill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: þ 3 Widowed 4 □ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ulth and Mental Hygiene. 27 is marked other than "I r traumatic event, the Mec Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James J. Whalen Michael J. Fox, Son 110 Hanover North Wales, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important; If item 27 is any injury or other trauonce. 110 Hanover Avenue, North Wales, PA 19454 Michael J. Fox, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Our Lady of Grace Cemetery 04/10/2007 Langhorme, Pennsylvania 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Harman Funeral Service, P.A. 21. Signature of Funeral Service Licensee M01113 SHW 7221 Grayburn Drive, Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician**) M/NNTES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an nas e 2 autopsy perform certificate ha 2E 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA မှ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending 1 ☐ Yes 2 No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 1044725 4-5-2007 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHARL WITTING Registrar's Signature 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State

Registrar

APR 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Year April 2007 Marjory (nmn) Fuller /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Air Health and Kenabilitation Cent If Under 24 Hrs. Hartord If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F **Director** 123-18-5109 Usual Residence of Decedent 2, New York 1911 96 Apr. death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 🏖 No Director Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 608 Burlington Court 21040 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. once. Black, White, etc. 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Packer <u>Veterinary</u> Supply 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry (nmn) Gardner Rose Belle Chase ္ရ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roland M. Gardner / Son 608 Burlington Ct., Edgewood, Maryland 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【I Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 4-6-07 Towson, Maryland 21. Signatur of Funeral Service I McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause in aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician sementi disease or condition resulting in death) ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause [Disease or n.jury that initiated events resulting in death) Last Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig , page 2 should b 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1∐ Yes 2/X No 2□ No or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner' 200 No Other: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA William Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier 🕰 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D56545 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHOSLA 206 HAYS ST #102, BEL AIR, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 0 2007 350 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar	State of Maryland	-	rtment of tificate of		nd Menta		ene 007	11252
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	/Medic		Nellie Theresa Fet					Apı	r. 5	5 2007	6:20 a. M
	Examin	er	4a. Facility Name (If not institution, give sti			4b. City, Town,		Death		4c. County of Dea	
			Manor Care-Rossvil 5. Social Security Number 6. Sex	.le 7. Age (In yrs. las	st birthday)	Rossvi If Under 1 Year		Hrs. 8. Da	te of Birth	Baltimo:	re httplace (State or Foreign
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	with th		10e. Street and Number			10f. Zip Code				g. Citizen of What C	•
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2	iled v dygie ther t		8 years 17. Father's Name (First, Middle, Last)		Home	maker	18 Mother's	s Name /First		Own Home	
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Maryland 21215-0036	should nd Me mark matic	ပ္	19a. Informant's Name/Relationship (Type	. Print)	19b. Mailin	a Address (Stree				City or Town, State,	Zip Code)
<u>8</u>	Ith ar Ith ar 27 is r trau		Maureen Rossbach (I			Stratmar				Maryland	
ē,	S 1 ag		20a. Method of Disposition	20b. Pla	ce of Dispos	sition (Name of natory or other pla	ace)	Date	20	Oc. Location - City o	r Town, State
Ë	Page nent o int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	IIIOVAI IIOIII State		Cemeter		/10/20	07 I	Baltimore	, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any futury or other traumatic event, the Markical Examination and be notified at ODGe.		21. Signature of Funeral Service Licensee			Name and Addr		. 7			-
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			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. cause on each line.	Do not ente	or the mode of dy	ing, such as ca	ardiac or resp	ratory arres	st,	Approximate Interval Between
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	ted nsit	Examiner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury								
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89	ntification of physical as the		IF FEMALE.								
Вох	eath certific ettending pl for use as t	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnand 1 Live birth 2 Fetal of		Ectopic pregnan	су			23d. Date of d	elivery Day Year
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	Hospita 24 hours Funeral etely filled	edical		F: On the basis of examination and manner stated.							
	To the Hospital or Attending Physician: The within 24 hours efter death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Me	29b. Signature and title of certifier			29c. Licer	ise number		29	d. Date signed (Mo	nth, Day, Year)
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	0		30. Name and address of person who con	pleted cause of death (Item 2	23a) (Type,	Print)		1), O	21061 14n/2, 40
				on 1842		bodi	ka S	te 12	20 (ofen bu	inne, 40
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. L. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Agnes I. Fenwick 4:40 PM APRIL 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore BALTIMORE HOSPITAL OF If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months 81 215-24-7024 10/18/1925 Director MD Usual Residence of Decedent 10a. State 10c, City, Town or Location 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD **Baltimore** TYYYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21209 USA 4800 Yellow Wood Avenue Apt. 315 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married トピハル・レK , Agnes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced African American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. food server State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Paul J. Saxon Bessie Taylor 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Agnes A. Davis / Daughter 2623 Cylburn Avenue; Baltimore, Maryland 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or of 1 Burial 2 □ Cremation 3 □ Removal from State Evergreen Memorial Garden's 04/12/2007 Lexington Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 North Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration prec days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unitarity, g Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed and -trans physician ar s the burial-ti Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as 1 the attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1☐ Yes 2 No
9☐ Unknown 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, þ Cerebrovascula accodents 1 Yes 2 No 3 Probably 4 Unknown Completed peen fibrillation Atnal 24a. Was an Were autopsy findings available prior to completion of cause of has page 2 autopsy death? 1 ☐ Yes Dabetes After this certificate 2□ No 1□ Yes 21X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA Division or 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending 1 Natural 2 Accident Injury (Month, Day Year) 5 Pending within 24 hours after deam.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar

8

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

KAN JAN1

jan Ramaratha

RAMANAMIAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SINAI

32./Begistrar's Signature

DHMH 17 Rev 1/2001

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APRIL 7, 2007

BATTIMORE 2401 W BELVEDERE AVE, BALTIMUR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician William Genick, arch 31 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Genesia Elder Care - Raven Center Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) (O 24 193) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 XM 2□ F Months Hours SC 215.28.1164 Yrs. Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County other treumstic event, if a Mudical Exactinar must be notified at MD Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 6621 Loch Raven Boulevard To Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (144or 5+) Ivansportation Driver 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be innent of Health and Mental I ant: If item 27 is marked o Lottie Pettis Jerod Gemick 19a. Informant's Name/Relationship (Type, Print) Gvan d 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a important: If item 27 is any injury or other tree once. 1221 Halstead Road Baltimore MD Nenssa Brynkley / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Windsor Mill, MD 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Park 0409 107 22. Name and Address of Facility Voughn C. Greene Funeral Services 21. Signature of Funeral Service Licensee 4905 York Road Baltimore MD 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) monia Physician /Medical Due to (or as *consequence of) Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dire to (or as a consequence of) Examiner sicien and burial-transit Division of Vital Records, P.O. Box 68760 $arphi_{C\!\!\!\!C\!\!\!\!C}$ or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): To Be Completed by Physician/Medical ettending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 1 Unknown 24a. Was an

After thi

Jewick, William

autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

1 Yes 2,K) No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

31. Date filed (Month, Day, Year)

5 Pending investigation 6 Could not be

1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of м

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

23a Cartifier (Check only one)

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

Medicai Certification;

Centifying Physician: To the best of my knowledge, death occurred at the line, date and place and the cause (s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Centifying Physician: To the best of my knowledge, death conumed at the time, date and place and due to the cause(s) and manner as stated

29b. Signaturé and little of certifier

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determined

29c. License number

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed

Hospital:

State Registrar

32. Registrer's Signature

within 24 hours effer death. To the Funeral Director: A

To the Hospitel

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filled in by

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 3 2007 11:40% Craig B. Gilliam

4a. Facility Name (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 4604 Cascades Mills # L Owings Mills # L

7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | (Month, Day, Year) | 5 / 8 / 1 9 5 1 9. Birthplace (State or Foreign Country) MD 5. Social Security Number 6. Sex 1 ØM 2 ☐ F **Funeral** 217-54-1542 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medica Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Owings Mills 1 TYes 2 TANO MD Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 USA 4604 Cascades Mills Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1ĂÎYes 2☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: African-3 ☐ Widowed 4 ☐ Divorced American Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Post Office Bunt Sorter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Walker Calvin Gilliam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 4604 Cascades Mill Dr. # L, Owings Mill S, 19a. Informant's Name/Relationship (Type. Print) Saundra K. Gilliam/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4/9/07 Garrison Forest Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylle F/H P.A. of Balto. Col. 21. Sign ture of Funeral Service Licenses 9200 Liberty Rd., Randallstown, MD 21133 29a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Colon **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be execute Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 **X**No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certificat 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Navier of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/4/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste#340 17 1 23 Crussroads in . D. Howard Jaiout 2 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 0 2007

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician MORTON 4, 2007 **GOETZ** APRIL 5:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FUTURE CARE CHERRYWOOD NURSING HOME REISTERSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Funeral 1 X M 2 □ F Director 218-09-1377 11/06/1920 86 MD Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland palith and Mental Hygiene.
n 27 is marked other than "natural" or thome 220 or 200 of 100 of 100 or 100 of 10 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 □ Yes 2 No Directo MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 2724 WOODCOURT ROAD 21209 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status XYes 2 No fYes Give 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ WHITE 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALES CLOTHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DAVID **GOETZ** ၉ MATILDA SILVERSTEIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MARK GOETZ / SON 2724 WOODCOURT ROAD, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HEBREW YOUNG MENS 04/08/2007 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has briector, page 2 s autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) 1 ☐ Yes 2 70 2 ER/Outpatient 3 DOA ၉ 1 🔲 Inpatient funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office ; building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20

32. Registrar's Signature

The District

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29c. License number

29d. Date signed (Month, Day, Year)

51136

DHMH 17 Rev 1/2001

Registrar

Course

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 Year ADr11 5:00 Ам Constance Sophia Garrison 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Mariner Health Of Overlea Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 2/8/1924 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex 9. Birthplace (State or Foreign Year) 1 M XX F 83 Mississippi 219-16-4267 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6116 Belair Road 21206 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White 3XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Book Keeper Property Manager 18. Mother's Name (First, Middle, Majden Surname) 17. Father's Name (First, Middle, Last) Peter E. Boney Sophia R. Paszkiewicz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Leona R. Mellon / Sister 10000 N.W. 4th Street Plantation, Fl. 33324 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Hill Top Serv. Corp. 4/9/2007 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21214 5305 Harford Road Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final raiac disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23d. Date of delivery 3 Ectopic pregnancy Month Year Day

Physician /Medical Examiner

that the death certificate be executed

t een signed by t should be detach

has

this After this funeral of

within 24 hours after death **To the Fune**ral **Director**: сотрletely filled in by the

death.

page

Box 68760,

Division or Vital Records, P.O.

The law

Physician:

To the Hospital or Attending

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once.

Physician

/Medical

Examiner

Funeral

Director

28a-f show notified at

"natural", or items 23a or ? idical Examiner must be n

the Medical

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Funeral

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Completed

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death with the Maryland

filed within 72 hours after Hygiene.

and 2 should be filed within ealth and Mental Hygiene. It 27 is marked other than '

Baltimore, Maryland 21215-0036

Examiner physician ar Physician/Medical as attending | for use as ed by the detached

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Completed

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Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

9 Unknown

4 ☐ Homicide

(Check only

29a. Certifier

l	d Hype
	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown

5 Other (specify)

23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? 1∐ Yes 26. Place of Death (Check only one) Hospital: Other:

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 □ No 4 Aursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

25. Was case referred to medical examiner? 1 ☐ Yes 2500	Hospital: 1 ☐ Inpatient 2 []ER/Outpatient	3 🗆 [DOA
27. Mapper of leath 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c
3 Suicide 6 Could not be		nome, farm, stree	t, facto	ory, o

28c. Injury at Work? 28h. Time of 1 ☐ Yes 2 □ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and the of certifier	
Magn N	W.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1	V	1	/	1	7	V
3	1.	Date	filed	(Month,	Dav.	Yes

5601-6 32. Registrar's Signature aven Black, Baltimore my 2/239

State Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem Z7 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, HENRY GREEN Sta Registr

	Please Type or Print in State of Maryla	and / Dep	artment of H	ealth and M	•	_			
	1 - State Registrar	Ce	rtificate of L	Death	Reg	No.2 1 7	11259		
	1. Decedent's Name (First, Middle, Last) HENRY GREE	N			2. Date of Death Month APR • 7	Day Year 2007	3. Time of Death 8:30 PM		
	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	th		
	STELL MARIS -DULANEY		TOWSO	N		BALTIM	ORE CO.		
		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Bir	thplace (State or Foreign		
	213 07 5744 ¹ X 98	Yrs.	Wioning Days	Tiodis Iviin.	SEPT.18	3,1908	CAROLINA		
	Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or L	ocation				10d. Inside City Limits		
	Total State Total County	Oity, Tollinoi E	oodiion				y Yes 2 No		
	MD N/A	BALTI	MORE CIT	¥	100	. Citizen of What Co	24		
í			10f. Zip Code	1.0	109		Suntry:		
combiced by I diletal biletal		nIIS 13	Was Decedent of Hi		cify Vas or No.	USA 14. Race - Ame	erican Indian.		
3	Armed Forces?	11 0.0.	If Yes, specify Cuba	n, Mexican, Puerto I	Rican, etc.)	Black, Whi			
5	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify: BI	ACK		
	15. Decedent's Education		edent's Usual Occupa		16	b. Kind of Business	-210-20		
1	(Specify only highest grade completed)	(Give	e kind of work done o DO NOT use retired,	luring most of workir)	ng				
5	Elementary/Secondary (0-12) College (1-4or 5+)	STEEI	L WORKER		BI	ETHLEHEM	STEEL CO		
3	17. Father's Name (First, Middle, Last)	· · ·		18. Mother's Name	(First, Middle, Ma	iden Surname)			
2	FRANK GREEN			MARGARE	T				
•	19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ing Address (Street &	and Number or Rura	l Route Number, C	City or Town, State,	Zip Code)		
	EDGAR GREEN SR. (son)	1925	5 E. 32n	d St. BA	LTO.MD	21218			
	20a. Method of Disposition	b. Place of Disp	osition (Name of ematory or other place	D	ate 20	c. Location - City or	Town, State		
	1 ☑ Burial 2 □ Cremation 3 □ Removal from State A ☐ Donation 5 □ Other (Specify)		MEMORIA	L PARKR.	13,2007	, BALTO,MD			
	21. Spriture of Funeral Service Licensee	2	2. Name and Addres						
	Permadeno 71 hours	100	22. Name and Addres	B. SCRUG	GS FUNE	ERAL HOM			
	23a. Part1. Enter the disease, or complications that caused the	leath. Do not en	iter the mode of dying	g, such as cardiac o	r respiratory arrest	LTO, MD.	21213 Approximate		
	shock, or heart failure. List only one cause on each line. Immediate Cause (Final						Interval Between Onset and Death		
	disease or condition resulting in death) PNEUMONIA Due to (or as a con	noguence of):							
	bue to (or as a con	sequence or,							
;	Sequentially list conditions, if any, leading to immediate b. Due to (or as a con								
	Cause (Disease or injury								
2	resulting in death) Last C Due to (or as a con	sequence of):							
	d								
5									
	IF FEMALE: 23c. If yes, outcome pf pre 23b. Was decedent pregnant					23d. Date of de	livery		
2	in the past 12 months? 1□Live birth 2□I		□Ectopic pregnancy □ Other <i>(sp</i> ec <i>ify)</i>			Month	Day Year		
2	9 ☐ Unknown 9 ☐ Unknown								
completed by rugalciallymedical	Part II. Other significant conditions contributing to death but not	resulting in the u	underlying cause give	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?		
2					1 ☐ Yes	2 □ No 3 □ P	robably 4X Unknown		
-					24a. Was an	24b. Were a	utopsy findings available		
1					autopsy	prior to death?	completion of cause of		
1	25. Was case referred to medical		. =	26. Place of Death		No 1 □Yes	s 2 No		
	examiner?	2 ☐ ER/Outpatie	ent 3 DOA Othe	3r-		se 6 ▼ Other/Se	ecify) HOSPICE		
	27. Manner of Death 28a. Date of Injury	28b. Time			28d. Describe how		HUSPICE		
	1 Natural 5 Pending (Month, Day Yea 2 Accident investigation	r) Injury		<br Yes 2 ☐ No					
	3 Suicide 6 Could not be 28e. Place of injury - A	At home, farm, st	treet, factory, office	2	28f. Location (Stre	et and Number or Fi	aral Route Number,		
;	4 ☐ Homicide determined building, etc. (Sp	ecify)			City or Town,	State)			
	29a. Certifier 1 Certifying Physician: To the best of my	knowledge, dea	th occurred at the tin	ne, date and place,	and due to the cau	se(s) and manner a	s stated.		
	(Check only 2 Medical Examiner: On the basis of examiner and manner stated.	mination and/or i	nvestigation, in my o	pinion, death occurr	ed at the time, date	e and place, and du	e to the cause(s)		
	29b. Signature and title of certifier		29c. License			l. Date signed (Mon	th, Day, Year)		
			DL	13725		4/9/	67		
	30. Name and address of person who completed cause of death ((Item 23a) (Tvne		_ ,		1 1	/		
	DD TARTO WAIMOOD 2200 DIII AN			IMONIUM,	MD 21093				
	31. Date filed (Month, Day, Year) 32. Pagistrar's S	ignature	A.						
	APR 1 0 2007 Seem	B A	100485						
-		9							

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

			Please	e Type or Pri						-		•	
		For State Registrar		State of M	laryland		partment c <i>ertificate</i> :				_	200-	7 11266
		Registrar Decedent's Name	e (First, Middle, I	Last)			erincate	OI DE	2111	2. Date of De	Reg. No. ath	4001	3. Time of Death
Physicia	_	Robi		reen						Month 3	Day 2	Year 07	7:53pm
/Medic Examin		4a. Facility Name (/	f not institution, g	give street and number	A		4b. City, Tox	vn, or Loca	ation of Death		4c.	County of Deal	
		Southern	Marylo	and hospato	y ce	nle	clin		MD			Prince	George
Funeral		5. Social Security N		.Sex 7.A 1⊠M 2□F	ge (In yrs. I	ast birthda Yrs	Months D		urs Min.	8. Date of Bird (Month, Da Nov 20	th y, Year)	9. Birt	thplace (State or Foreign ountry) rginia
Director		223-72-20 Usual Residence of			57	113				Nov 20	, 194	+9 V1	rginia
yland sow		10a. State	10b. County		10c. City	, Town or	Location		* -				10d. Inside City Limits
a-f sh	ctor	MD	Prince	George's	I	Distr	ict Hei	ghts					1 □ Yes 2√2 No
or 28	Funeral Director	10e. Street and Nur	mber				10f. Zip Co	de			10g. Citiz	zen of What Co	ountry?
ath w	ral	1996 Roc	helle Av					207			1.	USA	Y di
items ner m	nne	11. Marital Status	ied 2□ Marrieo	12. Was Deceden Armed Forces 1 ☐ Yes 2 🛛	?	S. 1	Was Deceden If Yes, specify	t of Hispan Cuban, M	ic Origin? (Sp exican, Puerto	ecify Yes or No Rican, etc.)	-	 Race - Ame Black, Whit 	
irs and	by	3 ☐ Widowed		If Yes, Give Year or Dates:			1 ☐ Yes 2K	No Sp	ecify:			Specify: b1	.ack
2 not latura ical E	ted	(Cnoc	15. Decedent's	Education		16a. De	cedent's Usual C	ccupation		ina	16b. Ki	nd of Business/	Industry
rnin / le. lan "r Med	b Be Completed	Elementary/Seco		grade completed) College (1-4or	5+)	life	ive kind of work on e. DO NOT use r	etired)	j most of wor	uig			
lygier lygier ner th nt, the		12	/F: 4 16:41	0		dis	sabled_	140		- /Fi A A A - d - d - d - d - d - d - d - d		one	
ntal H		17. Father's Name	(<i>First, Middie, L</i> a Lee Gree	•						e (First, Middle,		Surname)	
d Me mark matic	L L	19a. Informant's Na				19h M:	ailing Address (S			arlyn D		Town State	Zip Code)
Ith an 27 is it trau			lunde11/			71	0 Langst						
s 1 ar if Hea item 3		20a. Method of Disp	position			lace of Dis	sposition (Name or ematory or other	of		Date Date		cation - City or	
Page nent o			□Cremation 3 F Sther (Spe	□Removal from State	9	orrotory, c	romatory or onto	, piaco,	1				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Important of Health and Mential Hygiene. Important: If time Z7 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of E	neral Service Lic	wade Dia	cector		State Ar	ddress of	Facility Board	1 655 W.	Ba1	timore	Street
89 1 2 2		/ In	m/1	Mence	1		Baltimor	e. MI	2120)1			
		shock,\or hea	ırt failure. List or	omplications that cause nly one cause on each	ed the death line.	n. Do not	enter the mode o	f dying, su	ch as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
hysician /Medical		Immediate Cause (disease or conditio resulting in death)	(Final on	a. Hypo	xic +	H	perapr	veil	res	niratory	fo	vilme	
Examiner		3		Due to (or a		1 1 1	lo linh	0	DARIL	mania	,		
¥	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Right middle whe pneumomo Due to for as a consequence of):											
be executed cian and ourial-transit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events c. Seven Emphy semi						a					
e exe ian ar urial-tı		Λ											
To the Hospital or Attending Physician: The law fequires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria	Physician/Medical	La Acuté renal failme											
ding p	/Me	IF FEMALE:		23c. If yes, outcom	e of pregna	ncv						23d. Date of de	livon
atten atten	cian	23b. Was deceden in the past 12 1 Yes 2 [months?	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal	death	3 □Ectopic pregi 5 □ Other (speci					Month	Day Year
by the	hysi	9 ☐ Unknown		9□Unknown									
gned gedet	by P	Part II. Other signif	ficant condition	s contributing to death	but not resu	ılting in th	e underlying caus	e given in	Part I.				o the cause of death?
equir sen si ould t										10	Yes 2[□ No 3 □ Pi	robably 4 Uhknown
law law las be	Completed									24a. Was autoj	psy	prior to	utopsy findings available completion of cause of
cate l										1⊟ Yes	2 No	death? 1 ☐ Yes	3 2 □ No
siciar certif rector	Be	25. Was case refer examiner? 1 ☐ Yes 2 ☑		Hospital:	in at 0 0 1	ED/Outro	Nont 2000	Other:		th (Check only o			
r this er al di	: To	27. Manner of Deat		12 Inpat	jury	28b. Tim	tient 3 DOA e of 28c.	Injury at Work?	☐ Nursing H	ome 5 Resi			cify)
ath. r: Afte	atior	Natural 2 ☐ Accident	5 ☐ Pending investigat	ion (Month, D	ay Year)	Injui	м	work? 1 ☐ Yes	2 □ No				
r Atte er de: irecto i by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	200. Flace UI II	njury - At ho etc. (Specify	me, farm,	street, factory, o	ffice		28f. Location (a			ural Route Number,
ortal or rral Di			-1										
Hosp Pune Fune stely fi	edical	29a. Certifier (Check only one)	1 ♥ Certifying 2 Medical Ex	Physiclan: To the bes caminer: On the basis and manners	of examinat	wledge, de tion and/o	eath occurred at i r investigation, in	the time, d my opinio	ate and place n, death occu	, and due to the rred at the time,	date and	and manner as place, and due	s stated. e to the cause(s)
o the omple	Mec	29b. Signature and	I title of certifier	and manners	stateu.		29c. L	cense nun	nber		29d. Dat	e signed (Mont	th, Day, Year)
- 3 - 8		▶ Vito	ennen	MD				DO	63183	3	(101/01/0	7
		30. Name and add	ress of person wi	no completed cause of	death (Item	23a) (Tyı	pe, Print)			4 :		n-M	
		VIJI		KANNAN		503		tts	20010	1, cl	unho	n - M	り
Sta		31. Date filed (Mon	nth, Day, Year)	32. Regis	trar's Signa	ture	-						
Registr	ar	AF	PR 1 0 20	107 Marie	18.	12							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland / Dep.	artment of Health and rtificate of Death		ene 007	1261
	Physic	ian	1. Decedent's Name (First, Middle, Last)	11.		2. Date of Death Month	Day Year	3. Time of Death
N.	/Medi	cal		esia Holmes		03 2	27 2007	2000 M
	Exami	ner	4a. Facility Name (If not institution, give si	Center	4b. City, Town, or Location of Dea Baltmore	th	4c. County of Death	ı
*	Funeral Director		5. Social Security Number 6. Sex 10	M 2XF 7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min	8. Date of Birth (Month, Day, Y	(ear) 9. Birth	place (State or Foreign intry)
	ehow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Ba-f eh	Director	MD N/A	Baltin	none			1 XYes 2 □ No
	3a or 2	Dire	1721 Guilford Av	l.nue.	10f. Zip Code 212.00	10g	Citizen of What Cou	intry?
	oms 2	Funeral			Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Ameri	can Indian,
920	within 72 hours after death with the Maryland one. than "naturet", or Items 23a or 28a-1 show than "daturet" or Items 25a or 28a-1 show the Medical Examination must be notified at		1 Married 2 Married 3 Widowed 4 Divorced	1 ∐ Yes 2 🗶 No	1 Yes 2 XNo Specify:	to rican, etc.)	Black, White Specify: [3]	OICK
21215-0036	"natur	Completed by	15. Decedent's Education (Specify only highest grade	completed) (Give	dent's Usual Occupation kind of work done during most of wo	rking 16	b. Kind of Business/Ir	ndustry
212	be filed within 72 ho ital Hygiene. id other than "natur event, the Medical	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired) Inistrative Assis	1	Baltimon School Sus	tem
pu	be filed tal Hygid d other	Bec	17. Father's Name (First, Middle, Last)	6		me (First, Middle, Mai	iden Sumame)	10.7.
Maryland		၉	19a. Informant's Name/Relationship (Typ)	8V.	<u> Edit</u>			
	nd 2 s lith ar 27 is r trau		Jona han Holme	s/Sm 552	ng Address (Street and Number or Ri I Lothiun Road	0 11		21212
Baltimore,	m O b.		20a. Method of Disposition 1 2 □ Cremation 3 □ Re	movar nom State 1 1	natory or other place)		C. Location - City or T	
altin	필든만큼.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Westen	Clineten 04 R. Name and Address of Facility VO		Baltimov	
8	Derm Depa Impo eny i		I lew ll	4	905 York Road R	Ballimore	MD 21212	-
E	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one immediate Cause (Final	cause on each line.	er the mode of dying, such as cardial	c or respiratory arrest,		Approximate Interval Between Onset and Death
AR.	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence of):	of tarave	-150 PC.	•	
agli.		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				
7.	ecuted and -transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
8760,	ficate be executed physician and is the burial-transit	dical Ex		Due to (or as a consequence of):				
89	ertificat ling phy e as th	Medi	IF FEMALE:					
Вох	death certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 3□ 4□Pregnant at time of death 5□	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
P.O.	that the de ed by the detached	Physi	1 ☐ Yes 2 No 9 ☐ Unknown	9LJ Unknown				
ds,	98	þ	Part II. Other significant conditions contr	ibuting to death but not resulting in the ur	nderlying ca <i>u</i> se given in Part I.		co use contribute to t	
ecol	ne law require has been si ge 2 should b	Completed	Hypert	usion		24a. Was an	24b. Were auto	psy findings available
Vital Records,	n: The Icate h r. page		(,			autopsy performed	i? death?	mpletion of cause of
	/sicial s certii directo	To Be	25. Was case referred to medical examiner? 1 Yes We No	spital: 1 Inpatient 2 ER/Outpatient	Other	ih (Check only one)		
Division of	Attending Physician: r death. sector: After this certifications the funeral director.	on: T	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury	t 3 DOA 4 Nursing H	ome 5 Residence 28d. Describe how in		y)
risio	Attend death ctor: /	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, stre	M 1 Yes 2 No	28f. Location (Street	t and Number or Rura	I Pouto Number
á	ital or A		4 Homicide determined	building, etc. (Specify)	ost, radioly, office	City or Town, Si	tate)	ir Hobie Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Euneral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) Certifying Physic 2 Medical Examine	 ian: To the best of my knowledge, death r: On the basis of examination and/or invalid manner stated. 	occurred al the time, date and place estigation, in my opinion, death occu	, and due to the cause rred at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
	To the Comp	M	29b. Signature and tille of certifier		29c. License number		Date signed (Month,	* *
7		-	30. Name and address of person who com	cloted cause of death (here con)	D005189		4-4-2	t
	9		Sam Hou	301 St Paul	DOD 5189	Homore	MD 2	2120>
	Sta Registra		31. Date filed (Month, Day, Year)	32. Higistrar's Signature	ente			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** John Franklin Horner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Fown, or Location of Death County of Death Examiner If Under 1 Year | If Under 24 Hrs. Security Number ge (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 □ F Yrs. Director 219-07-4655 Maryland Nov. 27. 1920 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐ No Directo Maryland Baltimore Rosedale 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8112 Poplar Avenue 21237 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If **X**es, Give 1 Never Married 2 Married WW II 1 ☐ Yes 2 ☒ No Specify: White Specify. 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 years Millwright Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony John Horner မှ Annie L. Brennan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8112 Poplar Avenue Baltimore, Maryland 21237 <u>Zada Hurd</u> (Companion) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 4/12/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. alk 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause useach line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed for use as the burial-tran Due to (or as a consequence of): attending physician IF FEMALE: 23c. if yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a or Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has b page 2 s autopsy perforn certificate 1☐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this within 24 hours after death.

Vo the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the I 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) VASILIADES, M.D DO064755

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Registrar's Signature

Reside

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year HITZELBERGER IAN 0445 PFI 2007 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPICINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1√2 M 2□ F 57 219-52-8935 Oct. 4, 1949 Maryland Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🖁 No Maryland Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2819 Ross Avenue 21219 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2√2 No Specify 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 years Pressman-American Can Co. Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John W. Hitzelberger Sylvia M. Hopkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jo Anne Hitzelberger (Wife) 2819 Ross Avenue Edgemere, Maryland 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Oak Lawn Cemetery 4/11/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

Physician /Medical Examiner

certificate be executed

Division or Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien. Important: if item 27 is marked other the any injury or other traumatic event, the any once.

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

physician and s the burial-tran attending pl signed by the a

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

To the Hospital or Attending Physician:

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940

32/Registrar's Signature

NAHAS

APR 1 0 2007

	Immediate Cause (Final	one cause on each line.					Onset and Death
	disease or condition	a. Intraventricu	lar Hem	orrhage			I week
	resulting in death)	Due to (or as a consequence	e of):	-			
ē	Sequentially list conditions,	b. Due to (or as a consequence	e of):				
Ē	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(
gu	that initiated events resulting in death) Last	c					
ω	recounty in death, Edet	Due to (or as a consequence	e of):				
ca	•	d					
edi							
by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnancy				23d. Date of deliv	
a l	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death				Month	Dav Year
Si.	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unknown	5 ☐ Other (spec				•
P.							
5	Part II. Other significant conditions of	ontributing to death but not resulting	in the underlying cau	se given in Part I.			the cause of death?
b					1 ☐ Yes	2 → No 3 □ Pro	bably 4 □Unknown
Completed					24a. Was an	045 144000 0004	anno Godinas a salabia
dr.					autopsy performed?	prior to co	opsy findings available ompletion of cause of
ਨੁ					1□ Yes 2 □		2□No
Be	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)		
	1 Yes 2 No	Hospital: 1 □ Inpatient 2 □ ER/0	Outpatient 3 DOA	Other: 4 Nursing I	Home 5 Residence	6 ∏Other (Spec	ifv)
Ξ.	27. Manner of Death	28a. Date of Injury 28b	. Time of 28d	. Injury at Work?	28d. Describe how in		,,
흗	1 □ Matural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
Ca	3 Suicide 6 Could not be				000 1 101		
Ħ	4 ☐ Homicide determined	building, etc. (Specify)	iaini, street, iactory, t	mice	28f. Location (Street and City or Town, Sta	ana Number or Hui ite)	ral Houte Number,
ပ္ပ		₹).					
ā	29a. Certifier 1 Triffying Ph	ysician: To the best of my knowled	ge, death occurred at	the time, date and plac	e, and due to the cause	(s) and manner as	stated.
Medical Certification: To	one)	niner: On the basis of examination and manner stated.	and/or investigation, in	i my opinion, death occ	urred at the time, date a	ind place, and due	to the cause(s)
š	29h Signature and title of certifier		29c I	icense number	20d F	Note signed (Month	Day Voorl

29c. License number

RES - 000

AVENUE BALTIMORE, MD 21224

29d. Date signed (Month, Day, Year) APRIL 7,2007

DHMH 17 Rev 1/2001

State

Registrar

				ase T									II Copies		_	ble.		
			1 - For State Registrar		Olale (Ji Iviai	ylaria /	-		te of i			nemai i i		No.	A ***	1 1 (,
			1. Decedent's Name (First, Mida	le, Last)	_								2. Date of D	eath	20	U /	3. Time of D	eath
B	Physici /Medic		Nora Eloise J	acob	s				Month Day April 07, 2					Day • 2001	Year 7	03:20	a™	
1	Examin		4a. Facility Name (If not institution			ımber)			4b. City, Town, or Location of Death 4c. County of Death									
	.a		Stella Maris			1 - 4				wson	I IZ I I a da	0411-			Balt	imor		
н	Funeral		5. Social Security Number	6. Sex 1□	M 2 X F	7. Age ((In yrs. last	t birthday) Yrs.	Months	er 1 Year Days	Hours	r 24 Hrs. Min.		(Month, Day, Year) Country)			ntry) `	Foreign
į.	Director		220–20–5167 Usual Residence of Decedent				80			L	L		05/09/	/192	26	Ma	ryland	
	ryland how	,	10a. State 10b. County			1	Oc. City, T	own or Lo	cation		-						10d. Inside City	
	Ba-f s	cto	MD	N	/A				Balt	imore	9						t x Yes 2	2 □ No
	with the	Dir	10e. Street and Number	_					10f. Z	ip Code				10g. Citizen of What Country?				
	sath v	eral	450 South Cha				Ever in U.S. 21229 U Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							Jnited 14 Bac		tes		
	fter de r Item	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Ma		Armed F 1 ☐ Yes	orces? 2 ☑ No					an, Mexica	an, Puerto	Rican, etc.)	0-		k, White,		
21215-0036	ral", o		3 Widowed 4 Divorce	ı l	If Yes, G Year or I	ive -			1 ☐ Yes	2 X No	Specify	·:			Specify	<i>/</i> :	White	
2-0	should be filed within 72 hours after death with the Maryland ud Mental Hygiene. marked other than "natural" or Items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Completed by	15. Decede (Specify only high	nt's Educ	ation completed)	1	6a. Deced	kind of v	ork done i	during mo	st of work	ing	16b	. Kind of B	usiness/In	dustry	
121	within lene. than "he Mec	ldm	Elementary/Secondary (0-12)		College	(1-4or 5+)		life. I	DO NOT	use retired	1)							
	filed y	ပ္သ	12 17. Father's Name (<i>First, Middle</i>	, Last)				Н	omen	aker	18. Moth	er's Nam	e (First, Middle	e, Maio		Hom	е	
an	lid be lental rked o	To Be	John Campbell									No	ra Flec	:k				
Maryland			19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or T								ty or Town,	State, Zij	Code)					
	ss 1 and 2: of Health ar item 27 Is other trau		Nora Eileen H	all_	(Daugh	iter)		406	Glen	wood	Road				yland			
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once,		20a. Method of Disposition ★ Burial 2 □ Cremation	3 □ R	emoval from	State	20b. Place ceme				1		Date		. Location -	City or To	own, State	
Iţim	it. Pa rtmen rtant: njury		4 Donation 5 Other (Ceda	ar Hi	11 C	emete	ery	04/1	1/2007	Br	ookly	n Pa	rk, MD	
Ba	permi Depa Impo any Ir		21. Signature of Funeral Service	Z				1	107	and Addres	SS OF FACIL	""Hubl	bard Fu	iner	al Ho	me,	Inc. and 212	20
	J 8 7 3		23a. Part1. Enter the diseas , shock, or heart failure. Lis	r complic	cations that	caused th	ne death. [·	3/ <u></u>		re, r.	агут	Approximate	
	Physician		Immediate Cause (Final disease or condition	t only on													Interval Betwee Onset and De	eath
	/Medical		resulting in death)	a a			SCULA consequen		CIDE	MI								
	Examiner		Sequentially list conditions,	b														
	ed sit	ine	if any, leading to immediate cause, enter Underlying Cause (Disease or injury)															
	executed an and rial-transit	Examiner	that initiated events c															
760,				d														
6876	tificat ig phy as the	ledio																
Вох	th cer rendin	an/N	IF FEMALE: 23b. Was decedent pregnant	23	3c. If yes, ou 1□Live		pregnancy □ Fetal de		Ectopic	pregnancy	,					te of deliv		
П	e dea the att	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown		4□Preg 9□Unki		me of deatl		Other (MC	nth	Day Ye	ear
P.O.	hat th od by 1 detach	Phy	Part II. Other significant condit	ions con	tributing to	death but	not resultin	a in the u	nderlying	cause niv	en in Part	I	23e. Did	tobaco	co use cont	ribute to t	he cause of dea	ath?
ds,	The law requires that the death certificate be ite has been signed by the attending physicis age 2 should be detached for use as the bu	d by			g			3	,	3							bably 4 X]Un	
00	w req	Completed											24a. Wa	s an	24h	Were auto	opsy findings av	vailable
Be	The la te has age 2	omp											per	opsy formed 2 X	?		impletion of cau	
ta		Be C	25. Was case referred to medic examiner?	al							26. Plac	e of Deat	1□ Yes h <i>(Check only</i>		110	i Li res	2L N0	
<u>></u>	dis y	To	1 Yes 2 No	Н		Inpatient	2□ER	/Outpatier	ıt 3∏ [4 ⊔ N	ursing Ho	ome 5□Res	sidence	6 X IOth	er (<i>Speci</i>	fy) HOSPI	CE
n c	ding P		27. Manner of Death 1 Natural 5 Pendi		28a. Date (Mo	e of Injury nth, Day \		Bb. Time of Injury		28c. Injur Work			28d. Describe	how ii	njury occur	red		
Division or Vital Records,	or Attending after death. Director: Afte in by the fune	icat	3 Suicide 6 Could		28e. Plac	e of injury	- At home	. farm. str	M eet facto		Yes 2		28f Location	(Stroot	and Numb	er or Bur	al Route Numbe	ar .
ο	after after Direct	Certification:	4 ☐ Homicide determ	ninea	build	ding, etc.	(Specify)	, , , , , , , , , , , , , , , , , , , ,		.,,			City or To	own, S	tate)	er or riar	ai riodie Narribe	51,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th Sompletely filled in by the funeral		29a. Certifier 1 Certifyi	ng Phys	sician: To th	e best of	my knowle	edge, deat	n occurre	d at the tir	ne, date a	ınd place,	and due to the	e caus	e(s) and ma	anner as s	stated.	
	ro the Hovithin 24	Medical	one)			nner state		and/or in				eath occur	red at the time				to the cause(s)	
	T	2	29b. Signature and title of dertifi	er						9c. Licens				29d.	Date signe	d (Month,	Day, Year)	
	0				1-			-1 /		DH	5/	25			7/9	1/0	/	
	10		30. Name and address of person DR. TARIO MAH				th (Item 23 ANEY			י ת	ידאטאדי	TIM	MD 210	102				
2	Sta	te	31. Date filed (Month, Day, Year)	32.						LITON	LUPI	rw ZIC	,,,				
	Registr	ar	APR	10	2007	MA	s Signature	85.	GOGA									

within 24 hours a

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

NEEL KARNE

29b. Signature and title of certifier

32. Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

10

29c. License number

CENTER DRIVE

29d. Date signed (Month, Day, Year)

7-02444		Ple	ease Type											
Shellie Jean Joyne		- For State	Sta	te of M	aryland /		tment of l ificate of l		nd Menta	al Hygie	ene	21	0 (7 1126
Physician	<u>_</u> F	legistrar 1. Decedent's Name	e (First Middle	ast)		Certi	ilcale of i	Jean		2. Da	Reg ate of Death	. No		3 Time of Death
ical Examine المسلم			- (,,		She	ellie	э J.	Ċ	Joyneı	· M	onth arch 30, 2	Day Yea 1007	r	1402 hrs
	ŀ	4a. Facility Name (i		-	and number)		1	. City, Town, o	or Location of	Death		4c. County o		
	4	3903 Queer						Pikesville	Len i	o To :	D. A. C. Dist.	Baltimor		<u> </u>
Funeral Director		5. Social Security N 212-60-	8286	Sex	X F	(In yrs. las	Yrs.	If Under 1 Ye Months Da		Min. 8. I		-1955	Foreig	thplace (State or in untry) N.C.
áu l	<u> </u>	Usual Residence of 10a. State	f Decedent 10b. County			10c. City, T	own or Location	n						10d. Inside City Limits
Aaryland 28a-f show any 1 at once.		MD	Balto		X.	Рi	kesvi	lle						1 Yes 2 X No
the Maryland a or 28a-f sh tified at once	ᇙᅡ	10e. Street and Nur	mber		·			10f. Zip Code			10g	. Citizen of Wh	at Cour	ntry?
a or tifico		3903 Qu	eens L	ace	Street	ţ		2120	80			USA		
th with the m	2	11. Marital Status 1 X Never Marrie	ed 2 Mari		as Decedent I	Ever in U.S.		Decedent of F s, specify Cub				14. Race White		can Indian, Black,
11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 X Yes 2 3 3 Widowed 4 Divorced If Yes, Give Year						No		es 2 V	In specify			Specify:	В	lack
urs aft	⋛├	15. Decedent's Ed		or Date	S:	pleted) 1	I6a. Decedent's	Usual Occup	ation (Give ki		done 1	16b. Kind of Bu	siness/l	ndustry
72 ho		Elementary/Seco	ondary (0-12)	Co	llege (1-4 or 5	+)	during mos	st of working li	fe. DO NOT u	se retired)		G B	Μ	С
OO3(within iene er tha	Completed by	12th g			3 year	s	R	N Nu	cse					
filed of the filed		17. Father's Name								,		aiden Surname)	
ID 21215-0036 should be filed within 7 and Mental Hygiene 77 is marked other than natic event, the Medica	음 으										er, City or Tow	n, State	, Zip Code)	
MD and 2 sho alth and m 27 is aumatic		Neather	Joyne	r -	Mother	<u> </u>	408	N. Pat	tterso	on Pa	rk Ba	alto,	MD	21231
re, land Heal		20a. Method of Dis 1 X Burial 2		3 Ren	noval from Sta	to cre	ace of Dispositi ematory or othe	r place)		Dat		20c. Location -		
imore Pages 1 ment of H tant: If i or other		4 Donation 5	Other Spe	cify:		Woo	odlawn		_	4-10	0-07	Balto	Со	, MD
Baltimore, ME permit. Pages I and 2 St permit. Pages I and 2 St popartment of Health at Important: If item 27 injury or other traums		21. Signature of Fu	0	censee)			me and Addre				/H Eas		- 07000
Physician	+	23a. Part I. Enter th	ne disease, or o	omplication	s that caused	the death. [o not enter the	Mode of dyin	. Nort ig, such as ca	Ch Av	enue oiratory arres	Balto st, shock, or he	<u>, M</u> art	Approximate Interval
IMedical,	ŀ	failure. List on Immediate Cause (nly one cause o	n each line.	oke inha									Between Onset and Death
Examiner	-	or condition resulting			(or as a conse									
	اي	Sequentially list co		b. Due to	(or as a conse	quence of):					_			
		cause. Enter Under (Disease or injury t	erlying Cause	C.	,									
red msit	Examiner	events resulting in		Due to	(or as a conse	quence of):								
	- Eg	X UNPENDED)		NDED #28	, perM	E,g867.5/ 4.11.0	3/0 <u>7</u> IT						
60, cate be physici he buri		IF FEMALE:		23c.	If yes, outcon			7_11				23d. Date of		
687 certific nding se as t	an	23b. Was decedent past 12 months		1 _	Live birth Pregnant at	time of dea	th - =	Il death	3 Ectopic	pregnancy		Month	[Day Year
30x death ne atter	Š	1 Yes 2	No 9 🗸 Unkr	own 9	Unknown		⊃ Uth	er (Specify)						
O. I.		Part II. Other signi	ificant condition	ns contrib	outing to death	but not res	sulting in the un	derlying caus	e given in Par	t I.				the cause of death?
S, P uires th n signe d be d		Ethano	l intoxic	ation						— 1	1 Yes			bably 4 Unknown utopsy findings available
ord aw req as bee	Completed							_			autops perforn	y		completion of cause of
Rec The licate licate l	5										1 ✓ Yes 2		V Y	es 2 No
ital	8	25. Was case refer examiner?		Hospital	: 1 Innatio	nt 2 l	ER/Outpatient		Other	Nursing Ho		Residence 6	✓ Othe	r: Scene
of V g Phys reral di	<u>ا</u>	1 Yes 27. Manner of Dea	2 No	28	a. Date of Inju		28b. Time of In		njury at Work		_	ow injury occur	red	
Sion of strength death ctor: All y the fur	E	1 Natural 2 X Accident	5 Pendi		3 /30/200	7 ^{ar)}	unk	1	Yes 2X	1 (71)	biect i	nvolved :	in ho	ouse fire
ViSi or Att or Att or Att or Att	Certification:	2 A Accident 3 Suicide	6 Could	not be	Be. Place of In	jury - At hor	me, farm, street	, factory, offic	e building, etc	28f.	Location (St	treet and Numbate) 3903 (er or Ru Queer	ural Route Number, City IS Lace St.
spital D	5	4 Homicide	deterr		Specify) re									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death To the Function Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	g	(Check only 1 one) 2		ysician: To yner:On the	the best of m e başıs of exa	y knowledg mination an	e, death occurr d/or investigati	ed at the time, on, in my opin	, date and pla- ion, death occ	ce, and due curred at the	to the cause time, date a	e(s) and manne and place, and	r as stat due to th	ne cause(s)
To T To t	Medical	29b. Signature and			nner stated.				ense number		T			onth, Day, Year)
				l	/			0.0	C.M.E.			March 31,	2007	
7	1	30. Name and a												
U		Mary G. Ri		Deputy (Chief Medi	- 1		Penn Stre	et, Baltimo	ore, MD 2	21201			
Sta Registr	te ar	31. Date filed (Mor	APR 1	0 200	32. Regil ra	rs Signatur	e de la	me						
	_													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of Maryland / D	epartment of He Certificate of L		tal Hygiene Reg. No.	_ 0 0 1	11267
	Physicia		1. Decedent's Name (First, Middle, Last)	Con			Date of Death Month Day	Year - ZOOF	3. Time of Death
,	/Medic Examin	al -	INOM. & Son Y Na. Facility Name (If not institution, give stre	eet and number)	4b. City, Town, or	Location of Death		County of Death	
			Gonesis Kandalsta 5. Social Security Number 6. Sex	WN 9109 Liberty 1	hday) II Under 1 Year	allStown If Under 24 Hrs. 8. 1	Date of Birth		place (State or Foreign
	Funeral Director	2	248 70 8850 x ¹		Yrs. Months Days	Hours Min. NC	Month, Day, Year)	4 S.C	AROLINA
Ī	wend wow	}_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town		CD37			10d. Inside City Limits 1 XYes 2 No
	he Mar	ector	MD . N/A	BA.	LTIMORE CI		10g. Cit	tizen ot What Cou	
	h with t	al Dir	2861 FOREST GLEN	N RD.	2121			USA	
36	d within 72 hours effer deeth with the Marylend jene. Ir than "natural", or Itama 23a or 28a-f show the Madical Exandral must be nutified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Noivorced	Was Decedent Ever in U.S. Armed Forces? 1 Yes XXNo If Yes, Give Year or Dates:	13. Was Decedent of Hi It Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Origin? (Specify in, Mexican, Puerto Rica Specify:	Yes or No- an, etc.)	14. Race - Amer Black, White Specify: B	
21215-0036	n n	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	Decedent's Usual Occupi (Give kind of work done of life, DO NOT use retired	during most of working d)		(ind of Business/l	
	be filed wi tal Hygien d other th	Con	8TH 17. Father's Name (First, Middle, Last)	E	NTREPRENEU	JR 18. Mother's Name (Fi		NSTRUC Sumame)	TION
/land	S d as D	To Be	CLAUDE JOHNS			FLORENCE			(in Code)
Maryland	d 2 sho th end ! t7 le me treums		19a. Informant's Name/Relationship (Type PAWN L. JOHNSON		. Mailing Address (Street: 2861 FORES				
Baltimore,	permit. Pages 1 end 2 should Department of Health end Men Important: If Itam 27 la marka any injury or other traumatic <u>pnce.</u>		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place o	f Disposition (Name of ry, crematory or other place L UNITED M			ocation - City or STEVEN	s co.
3altii	permit. Page Depertment of Important: If any Injury or ottog.		2 Sonature of Funeral Service License		22. Name and Addre	ss of Facility 3. SCRUGGS			
	4034 d	`	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do	not enter the mode of dyir	PRESTON S	ST BAL'I espiratory arrest,	O, MD.	21213 Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	AIDS					Onset and Death
	/Medical Examiner			Hoga Kins	Lymphon	na			
&	led	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a consequence	Of)				
,092	ate be executed hysicien and he burial-transit	cal Exar	that initiated events c. resulting in death) Last	Due to (or as a consequence	of):				
89	eath certificate ettending phy for use as the		IF FEMALE:	ic. If yes, outcome of pregnancy				23d. Date of de	livery
.O. Box	D 0 D	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 Ectopic pregnanc 5 Other (specify)	у		Month	Day Year
٥.	quires that n signed by	þ	Part II. Other significant conditions conf	nbuting to death but not resulting	in the underlying cause gr	ven in Part I.		. /	o the cause of death? robably 4 []Unknown
of Vital Records,	The law requires that the site hes been signed by the page 2 should be detache	Completed					24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of s 2 No
Vita	sician: certific rector.	o Be	25. Was case referred to ical examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/O	Outpatient 3 DOA	26. Place of Death (Check only one) 5 Residence	6 ☐Other (Spc	эcify)
	D 0 0	 -	27. Manner of Death 1 Datural 5 Pending		Time of 28c. Inju	iry at 28 ork?] Yes 2 □ No	d. Describe how in	ury occurred	
Division	E 48 12 00	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)			f. Location (Street a City or Town, Sta	and Number or R	Tural Route Number,
_	the Hospital hin 24 hours e the Funeral in		(Check only 2 Medical Examin	ician: To the best of my knowledger: On the basis of examination a	ge, death occurred at the t and/or investigation, in my	ime, date and place, an opinion, death occurred	d due to the cause at the time, date a	(s) and manner a and place, and du	s stated. e to the cause(s)
_	To the Hospital or Atta within 24 hours effer de To the Funeral Directo completely filled in by the	Medical	29b. Signature and little of certifier	and manner stated.	29c. Licen	0.56.41.4		Date signed (Mon	
	ĺ		30. Name and address of person who co	mpleted cause of death (Item 29a	(Type, Print)	ertu Road	Rando	allstow	007 N, MD 21133
	S Regis	tate	31. Date liled (Month, Day, Jear) APR 1 0 200	32 Registrar's Signature	Marie 8	J			,
		4	7 17 31 A V LOC	The state of the s	Charles and the				

07-02573	
Samuel Johnson	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Partificate of Pa		Reg.	No. 200	7 1 26
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Last) SAMUEL JOHNSON	2	. Date of Death Month D April 4, 2007	ay Year	3. Time of Death 1628 hrs
,		4a. Facility Name (if not institution, give street and number) 4b.	. City, Town, or Location of Death	April 4, 2007	4c. County of Death	
E		Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimbre If Under 1 Year If Under 24Hrs.	8 Date of Birth/	N/A MM/DD/YYYY) 9. Birth	iplace (State or
Funeral Director		250 22 8637 1 May 2 F 82 Yrs.	Months Days Hours Min.	JULY 2	Foreign 20,1924 Cou	SOUTH
' any		10a. State 10b. County 10c. City, Town or Location	1			10d. Inside City Limits
laryland 8a-f show at once.	ţ	MD • N/A BAL	TIMORE 10f. Zip Code	1100	. Citizen of What Coun	1 Yes 2 No
th the Mar 23a or 28a notified at		800 N. PATTERSON AVE.	21205		USA	
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once	Funeral	1 XNever Married 2 Married Armed Forces? If Yes 1 Yes 2 X No	Decedent of Hispanic Origin? (Specs, specify Cuban, Mexican, Puerto R		14. Race - Americ White, etc.	
urs afte tural",	à	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's	es $2\overline{X}$ No specify:		Specify: BLA 6b. Kind of Business/Ir	
16 n 72 ho ian "na ical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	t of working life. DO NOT use retired	d)		
5-003 led withii Hygiene. other th	Som	8TH DRI 17. Father's Name (First, Middle, Last)	VER 18.Mother's Name (I			CONCRETE
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	UNKNOWN	UNKNO			
s, MD 2121 and 2 should be fi lealth and Mental I tem 27 is marked traumatic event,	٩		Address (Street and Number or Ru N. PATTERSON E			///
		•	on (Name of cemetery,	Date 2	20c. Location - City or	Fown, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify: TRINITY C	EMETERY APR.	12,200	7 BALTO,	MD.
Baltimore permit. Pages I Department of I Important: If i		21. Signature of Funeral Service Licensee	me and Address of Facility ALVIN B. SCRUG	GS FUN	ERAL HOM	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	mode of dying, such as cardiac or r	espiratory arrest	, shock, of heart	proximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	ase			Death
		Sequentially list conditions, b				
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated C			546	
xecuted n and l - transit	il Exar	events resulting in death) Last Due to (or as a consequence of):				
60, ate be exe hysician a	edica	d. UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy				
Box 6876 death certificate he attending phy dor use as the b	ian/M	past 12 months?	I death 3 Ectopic pregnant	су	23d. Date of delivery Month D	ay Year
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of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should b	Completed			24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
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Vital Re hysician: Th this certifical	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient	26.Place of Death (Check or 3 DOA Other Nursing		esidence 6 Other	
ion of Vending Ph. eath. or: After the funeral	\vdash	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of In		28d. Describe how	w injury occurred	
Division tal or Attendir 15 after death. al Director: A	catic	2 Accident Investigation 28e Place of Injury - At home farm street	factory office building etc.	28f Location (Str	eet and Number or Rui	al Route Number City
Divi	Certification:	Suicide 6 Could not be determined (Specify)	Tablety, emed bending, etc.	or Town, Stat		arriado riampar, any
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurrence one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.				
- 5 Ki H	Me	29b. Signature and title of certifier	29c. License number	i	29d. Date signed (Mor	th, Day, Year)
		California (-	O.C.M.E.		April 6, 2007	
		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penr	Street, Baltimpre, MD 212	01		
St Regist	ate	31. Date filed (Month, Day, Year) APR 1 0 2007)			

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Registrar

State

APR 1 0 2007

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0/20 M 2007 APR Melvin J. Knott /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL BALTIMORE ST AGNES If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year, 7 / 6 / 1 9 4 0 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours 1 X M 2 □ F 66 Indiana 314-40-9160 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State a or 28a-f show be notified at 1 ☐ Yes 2 XNo Director Baltimore Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with 'Hygiene. Hygiene. vther than "natural", or items 23a or 's ent, the Medical Examiner must be n USA 21234 13 Teakwood Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Yes 2 No if Yes, Give 1 □ Never Married 2 N Married 1 ☐ Yes 2 No Specify: Specify: white Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Real Estate District Manager 1 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hiant: If Item 27 Is marked out Be Virginia Taylor Melvin M. Knott ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13 Teakwood Ct. Baltimore, MD 21234 Mary Mueller-Knott/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place Evans Funeral Chapel – Bel Air 20c. Location - City or Town, State Aprile 2007 20a Method of Disposition permit. Pages 1
Department of H
Important: If Itel
any injury or oti 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral And Cremation Chapel 8800 Harford Rd. Services Parkville, M21234 21. Signature of Fineral Service Licensee 1 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 card noma Cholang Physician Unknown /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of) attending physician Physician/Medical the IE FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the Ö 9 Unknown signed by t ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 4 Denknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ NO 24a. Was an page 2 s autopsy performed has certificate 1 Yes 2 1 NO Division or Vital 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To within 24 hours after death.

To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0063025 CHEEMA M.D. APR 06 2 007 AAMIR CHEEMA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOP OWINGS MILLS, 5/24 -STONE CIRCLE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 0 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician **P** M APRIL 2007 5:20 KORNHAUSER ETHEL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE ARDEN COURT BALTIMORE Birthplace (State or Foreign Country)
 Out O If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 8. Date of Birth | (Month, Day) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 🗆 M 10/14/1917 OHIO 89 Director 293-01-6847 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No SILVER SPRING MONTGOMERY MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 U.S.A. 15101 INTERLACHEN DRIVE APT. 218 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) he filed within 7 all Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) JEWISH COMMUNITY CENTER EARLY CHILDHOOD EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental REBECCA MILNER MILKOVE **JACOB** ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) THISTEL DELL COURT - OWINGS MILLS, MD 21117 Item 27 DAVID KORNHAUSER / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
Important: If iten
any Injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/08/2007 OWINGS MILLS, MD HAR SINAI CONG. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Marts 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 4 garc disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months?
1 ☐ Yes 2 █ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 🗌 Yes 22 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s perform rmear 2 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registra

State

Ernestine A. 1 31. Date filed (Month, Day, Year) APR 1 Dulaney

Valley

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300

32. Registrar's Signature

Wright

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Robert Owen Kusterer

		Registrar Certificate of Death Reg. No.											
Physici Medical Exami	. 1117	Robert Oven Kustonon								2. Date of Death Month Day Year April 6, 2007 3. Time of Death 0930 hrs			
)		4a. Facility Name (if not institution, give street and number) 8 Misty Wood Circle #C 4b. City, Town, or Location of D Cockeysville								4c. County of Baltimore			
Funeral Director		5. Social Security Number 218-54-2763								`	Birthplace (State or Foreign		
- Director	ŀ	Usual Residence of Decedent				10/06/1949 country) Maryla							
w any	ı	10a. State 10b. County	Doladonos	10c. City, T	own or Locatio				-		10d. Inside City Limits 1 Yes 2 X No		
daryland 28a-f show 1 at once.	Director	Maryland 10e. Street and Number	Baltimore		110	nonium 10f. Zip Code			10	0g. Citizen of Wh			
the Ma Sa or 28		8 Misty Woods Cir	cle Apt.C			21093				U.S.A.			
death with the Maryland or items 23a or 28a-f sho must be notified at once	uneral	11. Marital Status 1 Never Married 2 M	12. Was De arried Armed F			Decedent of Hisp s, specify Cuban,				- 14. Race White	- American Indian, Black, , etc.		
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2 hours "natur Ex mi	ᄝᆝ	15. Decedent's Education (Spe Elementary/Secondary (0-12)	cify only highest gra	de completed) 1-4 or 5+)		s Usual Occupationst of working life.				16b. Kind of Bus	siness/Industry		
5-0036 led within 72 hot Hygiene. other than "nat	omplete	12	4	,	Sal						ndustry		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medien	Be Co	17. Father's Name (First, Middle, Edward T. Kuste				1			irst, Middle, N Ekas	Maiden Surname)			
	ToB	19a. Informant's Name/Relations	hip (Type, Print)		1	•	and Numb	er or Rur	al Route Num	-	n, State, Zip Code)		
md 2 sho ealth and tem 27 is		Edward T. Kuster	er, Sr F	20b. Pl	ace of Disposit	odd Avenue			re, Mary Date	land 21200 20c. Location -	6 City or Town, State		
Baltimore, permit Pages I ar Department of Hee Important: If ite	П	1 X Burial 2 Cremation 4 Donation 5 Other S		rom State Cr	ematory or other	erplace) ith Cemete)4/10,	/2007	 Baltimore	e, Maryland		
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Physician	87 18	23a. Part I. Enter the disease, or	complications that	caused the death. I					Baltimo espiratory arre	re, Mary la	art Approximate Interval		
M i Examiner	9	failure. List only one cause Immediate Cause (Final disease	a. Hypertens	ive Atheroscle		vascular Dis	ease				Between Onset and Death		
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∞ ≒ ⊵ s l	ın/Me	IF FEMALE: 23b. Was decedent pregnant in the		outcome of pregna birth	ancy 2 Feta	al death 3	Ectopic p	oregnand	;y	23d. Date of Month	delivery Day Year		
Box 687 e death certifit the attending	Physicia	past 12 months? 1 Yes 2 No 9 Un	4 Preg	nant at time of dea		er (Specify)				Ì			
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Divisior pital or Attend ours after death erral Director: filled in by the	Certification:	2 Accident Inve	stigation	ce of Injury - At hor	me, farm, stree	t, factory, office b	uilding, etc.	. 2	8f. Location (S		er or Rural Route Number, City		
Div Hospital of 24 hours al Funeral I	Cert	4 Homicide dete	ermined (Specify			- 1 - 1 1 - 1					on stated		
To the Hos within 24 h To the Fun completely	Medical										lue to the cause(s)		
F 3 F 8	Me	29b. Signature and title of certifi		1/,		29c. Licenso				29d. Date signed April 7, 200	ed (Month, Day, Year)		
7		30. Name and address of person	n who completed ca	use of death (Item :	23a)	0.0.1	VI. E.			7,511,7,200			
5		/ /	puty Chief Med	ical Examiner	111 Pen	n Street, Balt	imore, N	1D 212	01				
S	tate	31. Date filed (Month, Day, Year)	A second second	Registrar's Signatur	e A	parel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 20 AM nnon 0 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bentalou Street Baltimore nder 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours Min. 1□M 2∏F 251-58-0109 87 Director 28. 1919 S.Carolina Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show Examiner must be notified at Baltimore 1 Nes 2 No Director N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b Pages 1 and 2 should be filed within 72 hours after death with 10 N. Bentalou Street 21223 USA items 23a Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No ğ Specify. Specify: Black 3XXVidowed 4 ☐ Divorced "naturai", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene Important: if item 27 is marked other than 'any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) Private families 3rd grade 17. Father's Name (First, Middle, Last) <u> Housekeeper/Nanny</u> 18. Mother's Name (First, Middle, Maiden Surname) Be Johnnie Chestnut Blanche Folks 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 N. Elnora Bullock/ Daughter Bentalou St. Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4/7/07 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Lorraine Park Cemetery Woodlawn, Maryland 22. Name and Address of FacilibChatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ase /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No 24a. Was an autopsy performed certificate 1∐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 No this (28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Medical Certification: 5 Pending investigation 1 ☑ Natural 2 ☐ Accident Injury 1 □ Yes 2 □ No within 24 hours after death. To the Funeral Director: A completely filled in by the for 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAEEM

DHMH 17 Rev 1/2001

ORIGINAL

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29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** APRIL 8:45 PM 08 JEORGE 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE NIA AGNES HOSPITAL SAINT If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F AUG. Director VIRGINIA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1XYes 2 No Directo MARYLAND BALTIMORE 10g. Citizen of What Country? 10e. Street and Number by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ■ Yes 2 □ No Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 ☐
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AFRO AMERICAN NEUSPAPER 12 + #GRADE 1) I RECTOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BER NICHOLAS ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 ROSEDALE, MD. 2/2
ate 20c. Location - City or Town, State MICHEAL 20b. Place of Disposition (Name of cemetery, crematory or other place) 4/10/2007 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 Removal from State 5 Other (Specify) 4 ☐ Donatien DALTIHORE MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility TK. FUNERAL HOME BROWN J145 N FULTON AVE, BALTO. MD. 2121 23a. Part1. Ent. If the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory frest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MeTASTATIC *RCINOMA UNKNOWN /Medical Due to (or as a consequence of): Examiner UN ISNOWN GRAM NEGATIVE RODS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner SACRAL be executed DECUBITU UN KNOWN and Due to (or as a consequence of): attending physician for use as the buria ASPIRATION Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9 I Inknown 9 Unknown cate has been signed by a page 2 should be detach ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, The law requires 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an autopsy performed? Yes 2 2 No certificate Vital 1□ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 212/No ဥ 1 npatient 3□ DOA 1 ☐ Yes 2 ER/Outpatient this 9 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending Injury s after dec. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suiclde 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20659 APRIL 09 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD. 21229 900 CATON AVE 1. KHAN HAFSA 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

APR 1 0 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland	-	rtment of F			giene ()	07 11275			
	Physici /Medio Examir	al	Decement's Name (First, Middle, Last)	Lane treet and number)		4b. City, Town, o	r Location of Deat	2. Date of Dea Month April	Day	Year 3. Time of Death O 7 8:15 p			
4	Funeral Director		21 - 12 1112			Westmi If Under 1 Year Months Days			Ca b, Year) 23,191	9. Birthplace (State or Foreign Country) 2. Maryland			
	Maryland a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Carro		nksb					10d. Inside City Limits 1 □ Yes 2 □ No			
	172 hours after death with the Maryland "natural", or Items 23a or 28a-f ehow relical Examinar must be notified at	Funeral Directo	10e. Street and Number 10 West Myer Dr 11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. W	10f. Zip Code 2104 /as Decedent of H Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No-					
5-0036	within 72 hours after ene. than "natural", or ite he Medical Examina	by	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	16a. Decede	Yes 2 No	Specify: ation during most of wo	rking	Specif				
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Maryland	s 1 and 2 should be I Health and Mental Item 27 is marked of other traumatic ev	2	James Arnold 19a. Informant's Name/Relationship (Typ Jeanette Hill —	pe, Print)			and Number or Ri		r, City or Town	, State, Zip Code)			
altimore,	permit. Pages 1 an Department of Heat Important: If Item 2 any injury or other once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 1 □ Donation 5 □ Other (Specify)	emoval from State Metr	e of Dispos letery, crem	ition (Name of atory or other plac ematory	April	Date	20c. Location	timore, Md.			
Bal	Depar Depar Impor		21. Signature of Funeral Service License J. Law L. License 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death.	110		stersto	own Rd.	Owing	al Chapel P.A s Mills, Md. Approximate Interval Between			
8760,	Physician and /Medical Examiner the pnial-transit the pnial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer Due to (or as a consequer	rce di):	arter	funct y di	1000 SEQS	e	Onset and Death I day ZOYS			
O. Box 6	at the death certifical by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Bc. If yes, outcome of pregnance 1 Live birth 2 Fetel de 4 Pregnant at time of deat	eath 3 🗆	Ectopic pregnancy Other (specify)	,			ate of delivery onth Day Year			
<u>a</u> .	law requires that the as been signed by th 2 should be detache	To Be Completed by	To Be Completed by	þ	þ	Part II. Other significant conditions con	- 1	ng in the uni	derlying cause giv	en in Part I.	1 🗆 Y	es 2 0 No	tribute to the cause of death?
	The ate h page			25. Was case referred to medical				26. Place of De	24a. Was a autop perfor 1 Yes	med? 2 No	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
ō	Phy ald			examiner? 1 Yes 2 No Hi 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		VOutpatient Bb. Time of Injury	28c. Injun Wor	er: 4 🗌 Nursing H		ence 6 🗹 Oth	ner (Specify) Huspics		
DIVIS	Hospitel or Attending 14 hours after death. Funerel Director: After tely filled in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al home building, etc. (Specify)				City or Tow	n, State)	ber or Rural Route Number,			
		Medical	(Check only 2 Medical Examin	ician: To the best of my knowle er: On the basis of examination and manner stated.	edge, death n and/or inve	estigation, in my o	pinion, death occu	urred at the time, o	date and place,	and due to the cause(s)			
	To the To the complex	<	29b. Signature and/title of certifier			29c. Licens			4	7,2007			
	خَ		30. Name Ind address of person who could be Richard St	epanacci i	0 3	zs0 5	tarting	Gate a	woo	7,2007 SBINE MD			
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 0 200	32. degistrar's Signatur	- Ann	A PA	/			,,,,			

DHMH 17 Rev 1/2001

ORIGINAL

Division or Vital Records, P.O. Box 68760,

within 24 hor **To the Fune** completely f

State Registrar

Medical

DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

ZHEN FAN,

29b. Signature and title of certifier

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D.

and manner stated.

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0060495

TOWSON MARYLAND 21204

29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: 24 hours a

State Registrar 29a. Certifier

(Check only one)

29b. Signature and little of certifier

31. Date filed (Month, Day, Year)

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APR 10

Medical

4000 OLD COUNT PLD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007



1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D40371

BALTIMONE, NO

29d. Date signed (Month, Day, Year)

4/6/07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. -3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 APRIL 7, JOSEPH LAWLOR, SR 2:10 A M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE OAK CREST VILLAGE CARE CENTER PARKVILLE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1√ M 2□ F 89 218-03-1451 07/07/1917 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 21 No MD Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 U.S.A. 8832 Walther Boulevard 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1. □ Yes 2 □ No I¥Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Business Manager masonry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Maher Lawlor John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4 Ale House Retreat; Savannah, Georgia John J. Lawlor, Jr / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 04/09/2007 Catonsville, MD 22. Name and Address of Facility 21. Signature of Euneral Service Licensee THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD.; TOWSON, MD 21286 rt1. Enter the disease, or complications that or sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia Due to (or as a consequence of) Sequentially list conditions, and to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ementio 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1 Yes 2 No 6 ☐Other (Specify) 27. Manur of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Box 68760, P.O. Division or Vital Records.

death certificate be executed signed by the a s after death.

al Director: After ed in by the funer. within 24 hours at To the Funeral D Hospital

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1

Physician

/Medical

Examiner

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Baltimore, Maryland 21215-0036

Director

Funeral

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Certification:

Medical

(Check only one)

29b. Signature and title of certifier

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APR 1 0 2007

31. Date filed (Month, Day, Year)

1,000-1,0

AX State 29c. License number

D61785

Boulevard Parhville, MD 21234

29d. Date signed (Month, Day, Year)

9

2007

and manner stated.

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Walther

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND THE #17, perFH, \$260,4/10/07, W.
State of Maryland / Department of Health and Mental Hygiene.

			1 - For State Registrar	State of Mary		partment of F ertificate of		d Mental Hy	giene	7 11279
	Physici		Decedent's Name (First, Middle, Last JEANNE Frances	•				2. Date of De Month April C	Day Yes	3. Time of Death
	/Medic Examir Funeral		4a. Facility Name (If not institution, give Sina' Hespita 5. Social Security Number 6. Se	street and number) 2 of Boolf x 7. Age (In	imere	Months Days	ore (eath	4c. County of D	1
	Director		212-26-2100 1L Usual Residence of Decedent	□M XXF 76	Yrs				1,1930 M	
	ryland how		10a. State 10b. County	10	c. City, Town or	Location				10d. Inside City Limits
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	with the or 2	Dir	10e. Street and Number 5406 Denmore A	venue		10f. Zip Code	215		10g. Citizen of What	Country?
	death	Funerai	11. Marital Status	12. Was Decedent Ever	r in U.S. 1	Was Decedent of H If Yes, specify Cuba		(Specify Yes or No	USA 14. Race - A	merican Indian,
5-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ont, ire McOlcal Exartinal notation actified at	þ	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:	deno rican, etc.)		hite, etc. Black
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Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	ee/		22. Name and Address 5240 Reis	ss of Facility C	hatman-l own Rd l	Harris Fu Baltimore	neral Home Md 21215
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Divis	el or Atte s after de il Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, pecify)	street, factory, office		28f. Location (S City or Tox	Street and Number or vn, State)	Rural Route Number,
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	To the within To the comp	ž	29b. Signature and title of certifier	n		29c. License			29d. Date signed (Mo	
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	Sta Registr		31. Date filed (Month, Day, Year) APR 1 0 2007	2. Registrar's S	Signature	all s				

DHMH 17 Rev 1/2001

Pahint known as Jeanne Matthews

			1 - For Amend 32	State of Maryla Per Phy G866	and / Depa 4/20/07	artme Th rtilica	nt of H te of L	ealth an Death	d Me	ntal Hygi	ene g. No.2 ()	0.7	11280
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**	/Medic	al	4h City Tourn or Local								4c. County	of Death	imore
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	Funeral Director		5. Social Security Number 6. S 216-20-8338	ex M 2□F 7. Age (In) 80	vrs. last birthday) Yrs.	Months	er 1 Year Days	Hours N	lin.	Date of Birth (Month, Day, March 4	Year) 1927	9. Birthi Coul Mar	place (State or Foreign ntry) yland
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Mary	and 2 should alth and Men 27 is marke er traumatic		19a. Informant's Name/Relationship (Mrs. Dolores McGa							Route Number, Luther			yland 21093
Baitimore,	permit. Pages 1 and 2 should Department of Health and Me Important: If Item 27 is mierk any Injury or other traumierito		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specific	Internoval from State 17	b. Place of Dispo cemetery, cre Vans Fu	osition (N matory o nera	ame of rother plac l Char	pel Ar	Dat or.7		oc. Location - Forest	-	own, State l, Maryland
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l I	ed sit	Examiner	b Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events Cause)								1 DAY		
8/60,	icate be executed physician and s the burial-transit	dical Exan	that initiated events resulting in death) Last	Due to (or as a cons)							
O. Box 62	ath certif ittending or use as	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal déath 3	□Ectopic □ Other (pregnancy (specify)					te of deliv	ery Day Year
Į.	res that the de signed by the a be detached f	by Phy	Part II. Other significant conditions	contributing to death but not	resulting in the u	underlying	cause give	en in Part I.		23e. Did tob	acco use cont	ribute to t	the cause of death?
SDJC	w requires that been signed b should be deta								_	1 Ye	s 2□No	3□ Pro	bably 4 □Unknown
II Kecora	The law ate has b page 2 sl	Completed							_	24a. Was an autopsy perform 1∐ Yes 2	egt?		opsy findings available ompletion of cause of 2 No
VItal	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	VIEDO -	-t 001	Othe	Ar.		Check only one			
0		n: To	27. Manner of Death	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Yea.	2 ER/Outpatie 28b. Time of Injury		28c. Injun Work	4 □ Nursir		d. Describe ho			fy)
DIVISION	Attending For death. rector: After by the funera	Certification:	Talatural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide 4 Homici								er or Rur	al Route Number,	
5	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu		29a. Certifier	nysician: To the best of my miner: On the basis of exan	knowledge, dea	th occurre	ed at the tin	ne, date and p	olace, an	nd due to the ca	use(s) and ma	anner as s	stated.
	thin 24	Medical	one) 29b. Signature and title of certifier	and manner stated.	1		9c. License				d. Date signer		
	× × × ×		De An	the K	2			5452					2007
′	41		30. Name and address of person who	completed cause of death (
2			TIMOTHY BESSEN 31. Date filed (Month, Day, Year)	1T M. D. 760 32. Registrar's S		R DF	RIVE	TOWSO	IN ,	MARYL	AND E	120	4
	Sta Registr		31. Date filed (World, Day, Tear)	0007	La .	1-1	20						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 **Physician** 1:55 AM ELEANOR MERRYMAN April 6, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford Months Days Hours Min. Feb. 23, 1919 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2X F 88 Maryland Yrs. 215-40-0471 Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director Forest Hill MD Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 2635 Chestnut Hill Road 21050 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I ant: If Item 27 is marked of Louis Smith Leah ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Shumate-daughter 2639 Chestnut Hill Road-Forest Hill, Maryland 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 10-07 Department of Important; If It any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery Parkwood Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
EVANS FUNERAL CHAPEL 8800 Harford Road AND CREMATION SERVICES Parkville, Maryland 21234 endial 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter of Jerging Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi Due to (or as a consequence of) Records, P.O. Box 68760, The law requires that the death certificate be Completed by Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown significant conditions contributing to death but hot resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 1∐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation after death. 1 🗌 Yes 2 No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide Medical

or Vital Hospital or Attending within 2

Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 21014 Qinglin Gao-500 Upper Chesapeake Medical Center-UPPer

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of-certifier

APR 1 0



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert William McDonnell State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle Last) Physician/ 2. Date of Death Month Day April 5, 2007 **Medical Examiner** 1021 hrs Robert William McDonnell 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or May 22, Foreign New 5. Social Security Numbe 6. Sex 7, Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign New Country)Jersey Months Days Hours Min. Director 54 1952 141-40-4990 1X XM 2 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits 1 Yes 2 X No s 23a or 28a-f show notified at once. 28a-f show Charlottesville VA Albemarle Director 1∩e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1046 Tupelo Court 22903 USA Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, is marked other than "natural", or items event, the Medical Examiner must be 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 X No Yes 3 Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify: white Specify: ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) within 72 hours 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Communications 12 2 Info. Sys. Mgr. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eileen Morehead James McDonnell Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 9 9 3 19a. Informant's Name/Relationship (Type, Print) Sherry McDonnell/ 1046 Tupelo Ct. Charlottesville, wife If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State April 8. Burial 2 🗙 Cremation 3 🔲 Removal from State hapei-F uneral Bel Air 2007 Forest Hill, MD Donation 5 Other Specify 22 Name and Address of Facility
Evans Funeral Chapel
And Cremation Services 8800 Harford Rd. Parkville, 21234 21. Signature of Funeral Savio License Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death Coronary artery thrombosus Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Atherosclerotic cardiovascular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to for as a consequence of Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical has been signed by the attending physician as 2 should be detached for use as the burial -X UNPENDED To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. of Vital Records, P.O. Box 68760, IF FEMALE: 23d Date of deliver 23c, If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown pleted 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed' page 1 🗸 Yes 2 No this certificate ✓ Yes 2 No To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: Other₄ examiner? 2 PER/Outpatient 3 LOOA Nursing Home 5 Residence 6 Other: Inpatient 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 X Natural Division 1 Yes 2 No Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. April 7, 2007 Jeel asha 30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31, Date filed (Month, Day, Year) egistrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

APR 10

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Murrill, Sr. Physician /Medical 4c. County of Death Town, or Location of Death Facility Name (If not institution, give street and number) Examiner NIA Greneral If Under 1 Birthplace (State or Foreign Country) vrs. last birthday If Under 24 Hrs 8. Date of Birth (Month, Day) Social Security Number **Funeral** 213.28.7899 1**№** M 2□F 03 14 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f show Exaπiner must be notified at 1 XYes 2 □ No MD Baltimore by Funeral Director 10g. Citizen of What Country? 10e. Street and Number USA Road Hillen 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. Affiled Folces: 1 Mayes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No "natural", or Specify: Black 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry the Medical College (1-4or 5+) Elementary/Secondary (0-12) Baltimore, Maryland 2121 Construction Drywall Finisher 7th Grade Department of Health and Mental Hygiv Important: If item 27 is marked other any injury or other traumatic event, <u>ti</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Clarence Murril Viola Walker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore MD 21218 Koa d Martha Murrill 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Owings Milb, MD 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison 04109/07 Forest 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jaughn C. Breene Funcial SINCS Baltimore MD 21212 4905 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of); cardi-Examiner Sequentially list conditions, leave, heding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the burial-transi Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Vear in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. I 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably cate has been sig, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes ٩ After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: A 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier. 29c. License number 30. Name and address of person who completed cause of death (Hem 23a) (Type, P. 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Year Z1: 23 M 2 regar F06. /Medical 4a. Facility Name (If not institution, give street and number, City, Town, or Location of Death 4c. County of Death **Examiner** nkins Hos more 8. Date of Birth (Month, Day, Year) Year If Under 24 Hrs. If I Inder 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours 1**∑** M 2□ F 213-64-6687 Director 12-25-1956 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 Yes 2 No Director MD NA Baltimore 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 3855 Elmora Avenue S A
Race - American Indian, 21213 Funeral ural", or items 2 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Yes 2 [X]
If Yes, Give
Year or Dates: Never Married 2 Married 2 X No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black Be Completed by 3 Widowed 4 Divorced "natural" 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Lab Engineer B. D. Diagnostic 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Frederick McCollum Bertha Mae Harlee ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3855 Elmora Avenue Darlene Finney -Friend Balto, MD 21213 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-13-2007 King Memorial Pk MD Randallstown, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H East 8 I ada MD 21202 was 1101 E. North Avenue Balto, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MO /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician use as t attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign. 2 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate Physiclan: 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 □ Inpatient 2 KER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending After Injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

HOSDI-2

Hopkins

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

he

Johns

32. Registrar's Signature

WPRATZ

APR 1 0 2007

31. Date filed (Month, Day, Year)

Keith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year 10-30 A M 07 Alice Faye Muhl 07 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death St. Agnes Hospital Raltmore 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct.14,1954 6. Sex 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 💢 F 52 226-82-4204 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Baltimore Catonsville MD 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21228 2 Stanley Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Oriole Park at Elementary/Secondary (0-12) College (1-4or 5+) Camden Yards 12 Chef 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Monasue Hall Gene Leslie Tucker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Stanley Drive, Catonsville, MD 21228 Howard Muhl, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 04/09/2007 Odenton, Maryland West Arundel Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harman Funeral Service, P.A. Fig Service Licensee 7221 Grayburn Drive, Glen Burnie, MD 21061 M01113 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPOTENSION 2 days disease or condition resulting in death) Due to (or as a consequence of): HEPATIC FAILURE ULMINANT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year in the past 12 months? 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ Mo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ETOH Cirrhosis 1 ☐ Yes 2 ☐ ¥6 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 NO 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

/Medical Examiner by the attending physician and tached for use as the burial-tran Box 68760 as t P.0. Records, certificate has or Vital Hospital or Attending Physician: After To the Funeral Director: completely filled in by the f within 24 hours a

To the Funeral I

Physician

/Medical

Examiner

Funeral

Director

a or 28a-f show t be notified at

iral", or items 23a Examiner must b

natural", or

is marked

Department of Health Important: If item 27 injury or other

Physician

Director

Funeral

ģ

Completed

Be

Examine

Physician/Medical

9

Completed

Be

Certification: To

Medical

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32 Registrar's Signature APR 1 0 2007

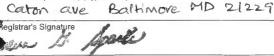
9005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

KRamern

Kolli Ramesh



P17602

APR 07 07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 2007 Gary Hughes Manifold 8:40 P M April 3, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min 1 XM 2 □ F Months Hours 202-36-8794 60 Oct. 16, 1946 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10h County a or 28a-f show t be notified at 1 ☐ Yes 2 No Director Marvland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 Wisteria Ct. North 21015 USA items 23a ed other than "natural", or items 23a event, the Medical Examiner must Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Was Decedent Ev Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 € No Specify. Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Systems Analyst U.S. Government permit. Pages 1 and 2 should be filed Department of Health and Mental Hygic Important: If Item 27 is marked other any Injury or other terminants. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Hughes Manifold Julia Sylvania Hersey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Linda M. Manifold/Wife</u> 304 Wisteria Ct. North, Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4-7-07 Stewartstown Cemetery 4 □ Donation 5 □ Other (Specify) Stewartstown, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P. A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** multiple Sclerosis rears) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ng physician and as the burial-tran Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) detached Yes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy perform 21 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 Yes 2∏No 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number

State Registrar W. A

31. Date filed (Month, Day, Year)

1041

6701

32. Aggistrar's Signature

N. Chowles St. Balto. Md Zi Zdx

30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗍 🗍 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Year 7 65 AM Margaret Emogene McClung /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** nortor HMIH If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□M 2፟∰F Months Feb. Director 10, 1932 West Virginia 235-44-8633 75 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Harford Air 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or Items 23a 410 E. MacPhail Rd. 21014 USA Completed by Funeral filed within 72 hours efter death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced White 'naturel' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Important: If Item 27 is marked other it
eny injury or other treumatic event, the Homemaker Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Syndey Lee Milem Emma Rose Collison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Johnson/Daughter 2415 Cool Spring Rd., Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 4-7-07 Baltimore, Maryland Gardens of Faith 21. Signature of Funeral Service Licensee McConas Funeral Home, P. A. / (usall 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Square and Death urkinsong Immediate Cause (Final disease or condition resulting in death) Privsician urun /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 27 No 1 🗌 Yes 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 Yes 2 No 1 ☐ Yes To the Hospinson within 24 hours after death.
To the Funerel Director: After this certifical the Funerel Director is the funeral director. 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: 1 Tes 2 PNO Other: ဥ 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Netural

2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and vace, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier, 29c. License number

Registrar

DHMH 17 Rev 1/2001

State

Yeelung, Margar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

APR 1 0 2007

state of Maryland Popularing of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 11:50 a. Walter Barksdale Markham, Sr. April 7. 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Parkville
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Oak Crest Care Center Baltimore 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1√2 M 2□ F Yrs. Director 219-01-6 92 Virginia May 2, 1914 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes 2 No Director Baltimore Parkville Maryland 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyghen. In amoprant if flem 27 is marked other than "natural", or tlems 23a or any nlury or other traumatic event, the Medical Examiner must be a 8810 Walther Boulevard, Apt. 2420 21234 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No 5/1933• INYes, Give Year or Dates: 5/1937 1 Never Married 2 Married 5-0036 1 ☐ Yes 2 No White Specify: \$ 3 Widowed 4 □ Divorced 1 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland 2121 Walter Marthan Elementary/Secondary (0-12) College (1-4or 5+) 9 years Machinist Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Otto C. Markham Brockwell. Maud 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1710 Brickhouse Lane Fallston, Maryland 21047 Walter B. Markham, Jr. (son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus 4/11/2007 Dundalk, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 21222 Wise Avenue Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failed. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequency of): =nd /Medical **Examiner** Spestosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tyes Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manne of Death 28d. Describe how injury occurred ul or Attending Pafter death.
I Director: After to in by the funera 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Fune completely f Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar

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revard

Parhville, MDZ1234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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APR 1 0

31. Date filed (Month, Day, Year)

8800 Walther Boy

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2007 7:20am April 7, RUTH B. NALE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Baltimore Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 1 □ M 2**X** F Months 214-05-9514 Yrs 89 West Virginia Aug. 19, 1917 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Parkville MD Baltimore 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 2625 Proctor Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nola Hanlein Thomas Wade Burger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2627 Proctor Lane-Parkville,MD 21234 Paul Thomas Nale, Jr-son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State April 13,2007 Elkridge, Maryland Meadowridge Cemetery 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8800 Harford Road EVANS FUNERAL CHAPEL Parkville, Maryland 21234 molias AND CREMATION SERVICES 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration 2 days disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 10nknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No autopsy performed' 1□ Yes 2∐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

/Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Division or Vital Records, P.O. Box 68760 been signed by the s should be detached certificate After this r death. within 24 hours after death

To the Funeral Director:
completely filled in by the

Physician

/Medical

Director

Completed by Funeral

Be

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Examine

Physician/Medical

Completed by

Be

Certification: To

Medical

3☐ Suicide

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Examiner

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

Registrar

man 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles

6 ☐ Could not be

determined

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2007

Pavika North Tousa MB 21204

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

32 Registrar's Signature

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DO043489

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 16:45 AM **Physician** 2007 Inez Nelson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 219-28-3285 1 □ M 2**X** F 02/16/1933 MD 74 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 XYes 2 No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2006 Druid Hill Avenue 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify. \$ 3 XWidowed 4 ☐ Divorced African American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 clothing maker warehouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Morrell Lillie Mae Henley ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saundra Griffin / Daughter 3024 Normount Court; Baltimore, Maryland 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 04/13/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service License, 638 North Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Knows disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Energy Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Vear 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Onknown UNG 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed Yes 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 11 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Records, P.O. Box 68760, FINT Division or Vital

Baltimore, Maryland 21215-0036

sician and bunal-transit the attending phase as t signed by the at d be detached for this certificate has ral director, page 2: or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i To the Hospital

Show

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei

BALTIMORE

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

(100025G)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ETIENNE 900 CATON AVENUE NGOUNGNIA

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar

State

Alaeur St

and manner stated

Months Days

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 2007 1:00pm M April 8, SHELLEY MARIE O'HANLON 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. | APRIL 15, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign

Physician /Medical Examiner

5. Social Security Number

217-11-9773

Usual Residence of Decedent

6. Sex

1 □ M 2 T F

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Funeral Director

or 28a-f show be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. "Instural", or items 23a or any hiury or other traumatic event, the Medical Examiner must be a pine.

Physician /Medical

Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician a s the burialattending pl for use as t has been signed by the 2 should be detached certificate ha within 24 hours after users...

To the Funeral Director: After the funeral py the fun

Be

P

Certification:

Medical

State

Registrar

10c. City, Town or Location 10a. State 10b. County BALTIMORE FREELAND MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 911 ZENITH DRIVE 21053 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: WHITE Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HUMAN RESOURCE HUMAN RESOURCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EILEEN TURNER JAMES DAVIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 911 ZENITH DR. FREELAND, MD 21053 JAMES DAVIS father Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition STABLERS CHURCH 1 □ Xurial 2 □ Cremation 3 □ Removal from State 4/12/2007 PARKTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility TIENRY W. JENKINS & SONS CO. 21. Signature of Funeral Service Licensee 16924 YORK RD. MONKTON, MD. 21111 BNACO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) >66212 Due to (or as a consequence of): extremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ yes 2 ☐ No 4□Pregnant at time of death 9□Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed Yes 2 No 1

29b. Signature and title of certifier

5 ☐ Pending investigation

6 ☐ Could not be

29c. License number

28c. Injury at Work?

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

26. Place of Death Check onl one

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year) 200

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1978 MARYLAND

10d. Inside City Limits

Approximate Interval Between Onset and Death

6 hour

24 hours

Year

4 Unknown

Day

1 ☐ Yes 2 ☐ XIo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WD 6 701 Mas.

31. Date filed (Month, Day, Year) APR 10

25. Was case referred to medical examiner?

1 Yes 2 No

27. Mann of Death

2 Accident

3 ☐ Suicide

29a, Certifier

4 Homicide

(Check only one)

1 Whatural

32, Registrar's Signature

28a. Date of Injury (Month, Day Year)

and manner stated.

Hospital: 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 9,2007 8:20 Mary Prendergast Pauline April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agate Assisted N/A Living Home Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗷 F 9 214-24-137 Director February 24, 1916 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the <u>Medical Examiner must be notifiled at</u> 1 Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5706 USA Denwood Avenue 21206 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give* Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry S Gerald M. Wallace Mattie ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) POA Rosalind Jones 5706 Denwood Avenue Baltimore, MD 21206 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State April 9,2007 Hanover, MD Anatomy Gifts Registry 4. Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Drive Suite P. Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Melaskases **Physician** (oncer /Medical Due to (or as consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence of: and Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by COPD 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No the Hospital or Attending Physician: ' hin 24 hours after death. the Funeral Director: After this certifica director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dether (Specify) Answer Lw 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M-D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLVD, M-D - 21221 MALIKA EASTERN NASEBM 709.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

Registrar

DHMH 17 Rev 1/2001

OBIONI

32, Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

ORIGINAL

2401 West Belvedore Avenue Baltimar, Maryland 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Angelstrar #26, perVerbal, 4/10/07 TT Certificate of Devit 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 5 PMM donth Year **Physician** Earl L. Purnell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Levindale NursingHome 7. Age (In yrs. last birthday) n/a Baltimore
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/14/1921 Birthplace (State or Foreign Country) **Funeral** 1X M 2□F Months Days Hours Min **Director** 217-16-1219 86 MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be flied within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4019 Fairfax Road USA 21216 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African American 1 ☐ Yes 2 No Specify: Specify: W☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) <u>5th</u> <u>Construction Worker</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sidney V. Purnell Lola Flemings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4019 Fairfax Road, Balto. MD 21216 Sonia Purnell/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) 4/12/07 Crownsville Vet. Crownsville, MD 22. Name and Address of Facility Wylie F/H P.A. of Balto. 21. Signatur of Funeral Service Licensee \$200 Liberty Rd., Randallstown, MD 21133 23. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** disease or condition resulting in death) 6 mars /Medical Due to (or as a consequence of): Examiner Se puntially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-tran Due to (or as a consequence of) Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 4⊡Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2☑No Hospital or Attending Physician; filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA ō 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of par on who completed cause of death (Item 23a) (Type, Print) ane 31. Date filed (Month, Day, 32 Agistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6, 2007 April 7:45 a. M Walter John Perzinski, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Edgemere 7322 Hughes Ave. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**反**M 2□F Oct. 1, 1957 Maryland Director 49 213-70-3540 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or tems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 XNo Director Edgemere Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21219 7322 Hughes Avenue Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2√ Married 1 ☐ Yes 2 ☐ No Specify Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Welder Manufacturing 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Perzinski Ida M. Lawson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edgemere, Maryland 21219 Helen Perzinski (Sister) 7322 Hughes Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/9/2007 Towson, Maryland 4 Donation 5 ☐ Other (Specify) Hilltop Service Corp. 22. Name and Address of Facility 21. Signatury of uneral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part1. Enter the dis shock, or heart all Immediate Cause (Final sease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, live. List only one cause on each line. Bythy Themic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause July and the initiated events Due to (or as a consequence of) Examiner requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) ☐Yes 2☐No 9 Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. β 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performe certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Box 68760 or Vital Records, P.O. The

Baltimore, Maryland 21215-0036

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dii Division To the Hospital within 24 hours a To the Funeral I

31. Date filed (Month, Day, Year)

Margaret Schemm

29b. Signature and title of certifier

29a. Certifier

Medical

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



mo

9512 Harford Rd.

29c. License number

29d. Date signed (Month, Day, Year)

Baltimore, Md. 21234

07-02590 Corey Pinkett Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Corey Pinkett	State of Maryland / Department 1- For State Certificate	of Death	2007 1129°
Physician/	1. Decedent's Name (First, Middle,Last)	2. Date of Dea Month	ath 3. Time of Death
Medical Examiner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	
. *	Johns Hopkins Hospital	Baltimore	40. Oddiny of Bodin
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		rth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	217 95 58 40 12 MM 2 DF 26	Yrs. Months Days Hours Min. 12 1/3	2:1980 Country) M19
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation	10d. Inside City Limits
<u>*</u>	M19 BA1+	iMOVE	1 Yes 2 No
Maryland 28a-f show <u>d at once.</u> rector	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
or death with the Maryland or items 33a or 28a-f she must be notified at one Funeral Director	5542 CEDONIA AUE	21206	USA
items items	1 Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.
after de	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 No specify:	Specify: BIAC /T
5-0036 ed within 72 hours aft tygiene. other than "natural" the Medical Ex ming Completed by	durin	dent's Usual Occupation (Give kind of work done g most of working life. DO NOT use retired)	16b. Kind of Business/Industry
36 nin 72 e. than " dieal	Elementary/Secondary (0-12) College (1-4 or 5+)	FER PROFFER	PrivEt Content
5-00 ed with tygien other	17, Father's Name (First, Middle, Last)	TER PROFFER 18.Mother's Name (First, Middle,	Maiden Surname)
21215-0036 uld be filed within 7 Mental Hygiene. marked other man cevent, the Media TO BE COMPIG	ROGER	INTEH JACQUEIII illing Address (Street and Number or Rural Route Nu	UE FOSTER
O di Bisi El _	19a. Informant's Name/Relationship (Type, Print) W. FE 19b. Ma LA RAE PINTETT 55		
re, MI s I and 2 s of Health a of If item 27 ier traum	20a. Method of Disposition 20b. Place of Dis	r other place) of A .	3 A 1 + x m p 2 / 206 20c. Location - City or Town, State
Pages nent of ant: 1	1 X Burial 2 Cremation 3 Removal from State 5+ 5+	n 12: 61 1 4-17-200	BAltimorE MA
Baltimore, permit Pages I as Department of He Important: If ite	21. Signature of Funeral Service Licensee 2	2. Name and Address of Facility 2431	Oliver St MO ED BALTI MORE
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not ent	er the mode of dying, such as cardiac or respiratory ar	rest, shock, or heart Approximate Interval
/Medical	faiture. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic cardi	ovascular disease	Between Onset and Death
Examiner	or condition resulting in death) Due to (or as a consequence of):	Carried Carried	
in the second se	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
0, — (c) to be executed sixian and purial - transit edical Examine	causs. Either Underlying Cause. (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
te be executed ysician and burial - transit	dd.		
o,0, e be exe ysician a burial -	XUNPENDED AMENDED #23a, 27, perME, 9867.	5/7/07 TT	
	23b. Was decedent pregnant in the	Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
b. Box 6876 the death certificat by the attending phy ched for use as the Physician/IM	4 Pregnant at time of death 5	Other (Specify)	
by the spring the fellow the spring Phys	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
Division of Vital Records, P.O. tal or stending Physician: The law requires that the state death as after death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be deated be retain to the Completed by Perification: To Be Completed by Perion 1.		1 Ye	es 2 No 3 Probably 4 V Unknown
Records, The law requires ficate has been signage 2 should be Completed		24a. Was	psy prior to completion of cause of
Recc The lav		perf 1 ✓ Yes	ormed? death? 2 No 1 Yes 2 No
cian: certifi ector,	25. Was case referred to medical examiner? Hospital: 1 Innatient 2 FR/Qutnal	26.Place of Death (Check only one) ient 3 DOA Other Nursing Home 5	Designation of Comme
of Vi Physi er this eral dir	1 V Yes 2 No 28a Date of Injury 28b Time		Residence 6 Other.
on c ending ath or: Af or: Af the fun	1 X Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	
Division o spital or Attending tours after death neral Director: Aft filled in by the fune Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	street, factory, office building, etc. 28f. Location or Town,	(Street and Number or Rural Route Number, City State)
Dj spital hours (meral y filled	4 Homicide determined (Specify) 29a Certifier A Continue Physician To the best of my knowledge death of		/a\
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Medical Certification: To Be Completed by Physician/Medical Ex	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of one) Wedical Examiner: On the basis of examination and/or investigation.	ccurred at the time, date and place, and due to the cal tigation, in my opinion, death occurred at the time, dat	e and place, and due to the cause(s)
To wit	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Certilles TC,	O.C.M.E.	April 5, 2007
\	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 F	Penn Street, Baltimore, MD 21201	
State	31 Date filed (Marth spars Veer) 39 Registrar's Signature		
Registra	31. Date filed (MAIN Play Fee) 2007	ask s	

			1 = For State Registrar	State of Marylan			t of Heal e of Dea			giene Reg. No.	007	11298
	Dhusisi		1. Decedent's Name (First, Middle, Last)						2. Date of De Month	Day	Year	3. Time of Death
	Physicia /Medic		Esther Julia Ros	enberger					April 7	7, 200	7	1:34 A M
	Examin	er	4a. Facility Name (If not institution, give s.			4b. City,	Town, or Loca	ation of Deat	h	4c. Co	unty of Death	
			Madonna Heart He 5. Social Security Number 6. Sex		(not high doub	Jar:	rettsv	ille Inder 24 Hrs.	Date of Bio		rford	
	Funeral Director			M 2CIF 88	Yrs.	Months		ours Min.	8. Date of Bir (Month, Da Mar. 1	ıy, Year)	Cou	place (State or Foreign intry) vland
			Usual Residence of Decedent						L'ECT . T	1919	Plat	yıanı
	unylan show	_	10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Ba-f	Director	Maryland Baltimore	e Mo	nkton							1 ☐ Yes 2 No
	with th	급	10e. Street and Number			10f. Zip			}		of What Cou	intry?
	eath	eral	1013 Maplehurst	Lane 2. Was Decedent Ever in U.	S 12 1	211		io Origina (S	pecify Yes or No	USA	Race - Ameri	ican Indian
_	r item	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 21② No		f Yes, spec	cify Cuban, Me	exican, Puerl	o Rican, etc.)		Black, White	
	ei, o	þ	3X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2√2 No Sp	ecify:		Sp	ecify:	Mhite
ה ה	72 hc	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	kind of wor	al Occupation	most of wo	rking	16b. Kind	of Business/Ir	ndustry
Y	nen nen	d m	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT us	se retired)		•	_		
7	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)		Homem	aker	19	Mother's Na	me (First, Middle		Home	
משב	d be antal l	o Be	William Soloman	Langlotz					A. Raube		mame)	
	shoul nd Me marl	우	19a. Informant's Name/Relationship (Typ		19b. Mailin	ng Address			Iral Route Numb		wn, State, Zi	p Code)
Ž	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other than "naturel; or iteme 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at		William A. Langlo	tz/ M ephew					, Monkto			
ย์	of He		20a. Method of Disposition		Place of Dispo	sition (Nan	ne of ther place)	1	Date	20c. Locat	ion - City or T	own, State
allillo	Pages ment of ant: if it ant: or o		Marial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	. Geor			4-10	0-07	Perry	man. M	laryland
<u></u>	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other ance.		21. Signature of Funeral Service License						Iome, P.			7
,0070	Cate be executed hysician and hysician and purial-transit the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the death of the distribution).	h. Do not ent						Marvi	and 21009 Approximate Interval Between Onset and Death
O. DOX O	The law requires that the death certificate be executed site has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	Ectopic pr				23d	. Date of delive Month	rery Day Year
corus, r	quires the an signed i	þ	Part II. Other significant conditions con Vernenha	tributing to death but not resi	ulting in the ur	nderlying c	ause given in	Part I.	23e. Did t		/	the cause of death?
Jac	The law reete hes be page 2 she	Completed	Hypo Hagewich								4b. Were autoprior to condeath?	opsy findings available ompletion of cause of
<u> </u>	clen: ertific actor.	Be (25. Was case referred to medical examiner?				26.	Place of Dea	ath (Check only			
5	Physi this c at dire	ဥ	TU TES ZE NO		ER/Outpatien			☐ Nursing F	T			(y) Assisted
5	ding h. After funer	to Lon	27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M	28c. Injury at Work? 1 ☐ Yes	2 [] No	28d. Describe	now injury o	ccurred	Living
DIVISION OF	To the Hospital or Attanding Physicien: The law within 24 burus eller deels. To the Funerel Director Atter this certificate has completely filled in by the funeral director, page 2.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str y)			2 110	28f. Location (City or To	Street and N wn, State)	umber or Rur	al Route Number,
	ne Hospit n 24 hours ne Funere	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred vestigation	at the time, da , in my opinion	ate and place n, death occu	e, and due to the urred at the time,	cause(s) and date and pla	d manner as a	stated. to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier			290	. License nun	nber		29d. Date s	igned (Month,	Day, Year)
)			Wind Kley	mo		D	3/295	p. 3		4/9	107	
	:0		30. Name and address of person who con	impleted cause of death (Item	п 23а) (Туре,	Print)	- 1-					
	10		31. Date filed (Month, Day, Year)	(0 JU) NCL	della Sp	- Jul	2 4202	10	WSIN	and	21204	/
	Sta Registr		APR 1 0 2007	DE. Negistrar s Signa	Space.	tes.						

State of Maryland / Department of Health and Mental Hygiene) For State Registra Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Month 3. Time of Death Day 2007 **Physician** March 31, 5:45 AM M William Reese /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sykesville Continuum Care Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept 9, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Director 85 215-32-1103 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23e or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2√7 No Director Carrol1 MD Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7309 Second Avenue 21784 USA permit. Pages 1 and 2 should be filed within 72 hours atter deeth v Department of Health and Mental Hygiane. Important: if item 27 is marked other then "naturel", or iteme 23e with Injury or other treumatic event, the Medical Examinat must once. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: unk 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) una unic 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Contiuum Care 7309 Second Avenue Sykesville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 🛛 Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Director Baltimore, MD 21201

23a. Pan 1. Enter the dis-less, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last 0 Examiner Due to (or as a consequence of) To the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit 5 5 Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ been si 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No r: After this certifice e funeral director, r Be 25. Was case referred to medical examiner? 20 Place of Death Check only one Other: 4 July sing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. J Director; And in by the f 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e 1 Caritying Physician: To the bast of my knowledge death occurred at the time date and place and due to the dause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Fignt) 30. Name and address of person 31. Date filed (Month, Day, Year) \$2. Registrar's Signature State APR 1 0 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 6 steven 3 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner MCI-H Hagerstown ashing Ton If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1**X**M 2□F 213-82-Director Maryland Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or Items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21746 18601 Roxbury Road USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygiens Important: If flem 27 is marked other thy eny injury or other traumatic event, if a once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be Delmus Rice 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Damron/niece 985 Patuxent Road Odenton, MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □Donation 5 ☑Other (Specify) in state 21. Signature of Funeral Servi S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 tons 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician**)a /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other 2 4 Nursing Home 5 Residence 6 Other (Specify) MCT-H 1 Inpatient 2 ER/Outpatient 3 DOA this the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Int is many 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number D0033471 30. Na see and sees of person who complet cause of seath (tem 23a) (Type, Print) A Waldorf,MD 20602 SAP1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6, April 2007 3:45 AM M Shirley Richardson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🔯 F 74 213-32-2373 Nov 5, 1932 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1√TYes 2□No MD Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with Inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or: 3820 Woodbine Avenue 21207 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: black han "natural", c 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) th retail jewelry manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Margaret McCall Shirley Rufus Diggs ဥ other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 15 Hunters Forge Court Owings Mills, MD 21117 Carla Richardson/daughter permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 ☐ Other (Specify) 21. Signature of Juneral Say S. Wade, State Anatomy Board 655 W. Baltimore Street Virector Baltimore, MD 21201 23a. Part1. Enter the disease or complications that caused the shock, or heart failure. List only one cause on each line. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NUM cons /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown bate has been signed bage 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Mnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate Yes Fo the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) W.S. Gu 1 Yes 2 Yo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Injury 5 Pending death, investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. and title of certifier 29d. Date signed (Month, Day, Year) 29b. Signature

State Registra

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ORIGINAL

6701 ~

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO 32. Registrar's Signature

Homes

Charles (+ Driver, no 21204

Patient Known as Isaac Steele

			For	State of Ma	aryland / Depa			Mental Hy	giene	(5) Em	
			1 - State Registrar		Cei	rtificate of L	Death		Reg. No. 2	07	302
н	Physici	an	Decedent's Name (First, Middle, La	ast)	-			2. Date of Dea	ath Day	Year	3. Time of Death
	/Medi		ISAAC		STE	ELE		April		2007	7:01 PM
	Examir		4a. Facility Name (If not institution, give				Location of Death		4c. County	of Death	
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	Funeral			Sex 7.Ag 1—2∏ M 2☐ F	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Year)	Birthpla Çount	ace (State or Foreign
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Maryland	2 should be f and Mental k Is marked of raumatic eve		19a. Informant's Name/Relationship	(Type. Print)	19b. Mailii	ng Address (Street a	and Number or Ru	ral Route Numbe	er, City or Town,	State, Zip	Code)
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Sre	of Hea		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 [Domaval from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac	e)	Date /	20c. Location -	City or Tov	vn, State
Ĕ	nit. Pages artment of I ortant: If ite Injury or o		4 □ Donation 5 □ Other (Speci		GARRIS	ON FORE	51:04-1	6-07	OWING:	5 Mil	125, MD
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m	e a E e				mo	2175 N.	FULTON	JAVE.	BALTO	. MD	21217
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1	/Medical		resulting in death)		a consequence of):	W1110 E 114	, ,				6 days
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Вох	leath certifi attending I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnancy			23d. Date Mor	e of deliver	y Day Year
	at the de by the a tached f	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant at 9∐Unknown	time of death 5L	Other (specify)					,
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a			Hypertension				-	1□ Yes	2 No 1	Yes :	2 PNo
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or Vital Records,	Physiclan: this certificated director, I	P	1 Yes 2 No 27. Manner of Death	28a. Date of Inju		III 3 DOA	4 □ Nursing H		dence 6 □Othe)
	ding l h. After funer	ion	1 ☑Natural 5 ☐ Pending	(Month, Da	Y Year) Injury	Work	yat <br Yes 2 □ No	zau. Describe i	now injury occurr	90	
Si	death death ctor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be	De Dace of init	ury - At home, farm, sti		res 2 🗆 NO	28f Location /	Street and Numbe	or or Puml	Pouta Number
Division	l or Attend after death Director:	Certification:	4 ☐ Homicide determined	building, et		ioot, radiory, onice		City or Tox	vn, State)	n oi nuiai	rroute Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying P	hysician: To the best	of my knowledge, deat	th occurred at the tin	ne, date and place	, and due to the	cause(s) and ma	nner as st	ated.
	24 h 24 h Fur etely	Medical		miner: On the basis o	f examination and/or in						
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed	Month, L	Day, Year)
	F > F 0		Jordan M. C.	commens M	D	RES	- DDD		April 7	201	07
	, 1		30. Name and address of person who				7 1 2			1	1
	441						of R.14	mare			
V	Sta	ate	31. Date filed (Month, Day, Year)	32 Registr	ar's Signature	ואו ופנטון	or mill	71.01			
	Regist		Jordan M. (31. Date filed (Month, Day, Year) APR 1 0 200	7	. H .						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 05 Physician APRIL 20:06 PM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Date of Birth (Month, Day, Year) 04 21 1952 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 214.64.8467 1**X**M 2□ F MD Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mertal Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show Important: It in the 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notifiled at MD Baltimore 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Ashland Avenue USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black White etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
2th grade College (1-4or 5+) American Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Sanders Gertrude Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paulette Sanders Ashland Avenue Baltimore MD 21202 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/10/07 Baltimore MD arrenmount Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Services ~ Mo1363 5151 Baltimore National Pike Balto. MD 2129 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 4 hows Immediate Cause (Final disease or condition resulting in death) DISSECTION RUPTURED AORTIC **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 1 Yes 2 No 3 Probably 4 Nnknown Completed HEART FAILURE CONGESTIVE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. e Funeral Director: A 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) RES-000 APRIL 05, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE BALTIMORE MD 21224 SUNIL KARHADKAR, MD

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

~ 32. Registrar's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Amend Item 3 per dr., g866,04/10/07dhb Certificate of Death	R	eg. No:	7 1	1304
		Physicia	n	1. Decedent's Name (First, Middle, Lest)	2. Dete of Deat Month	th	007	3. Time of Death
	N. S.	Physicia /Medic		4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Li	ocation of Deeth	26 Zo.	0 1	12:10p
	1	Examine	er	4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Li UNIVERSITY OF MARY LAND MEDICAL CENTER BALTI		40. County of	Dogui	
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Worth, Day 09-25-	Year) 9	. Birthplac Country)	e (State or Foreign
		Director		217-54-0311 1 M 200 F 48 Yrs. Wrs. Wrs. Wrs. Wrs. Wrs. Wrs. Wrs. W	104-25-	1958		MU
		srylend show	_	10a. Stete 10b. County 10c. City, Town or Location			10d.	Inside City Limits 1 Yes 2 □ No
		the Me	Director	MD 10e. Street and Number 10f. Zip Code	1	0g. Citizen of Wha	at Country	
d				810 Chauncey Avenue 21217		US	A	
0	_	ter de	Funeral	11. Marital Status	ecify Yes or No- Rican, etc.)	14. Race - Black,	White, etc.	
6	5-0020	5 Ta 🕮	Ď	1 Yes 2 No Specify:		Specify:	Bla	ck
A		n 72 h "natu	jetec	15. Decedent's Educetion (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	king	16b. Kind of Busin	ness/Indus	try
61	212	d within giene. er then "	Completed	Elementary/Secondary (0-12) Golege (1-4or 5+) Case Worker		State o	f Nk	aryland
,	and	# I 8 F	B	17. Fether's Name (First, Middle, Last) 18. Mother's Name 19. Should be a significant of the significant o	e (First, Middle, I	Maiden Surname)		•
10	Maryland	should by nd Menta marked umatic ev	္	Ha. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nymber or Rur	ral Route Number	r, City or Town, Sta	ate, Zip Co	ode)
36		C = 8 L		Anita R. Stewart (Sister) 810 Chauncey Ave. 1	3altim	ore, m)	D 21	217
13	Baltimore,	eges 1 e ant of Hee t: If item y or othe		20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of competery, crematory other place)		20c. Location - Cit	-	
The	altir	pemit. Pege Depertment of Important: If any injury or pnce.		1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature 1 Fungal Service Licens 22 June aud Address of Fugure 22 June aud Address of Fugure 23 June 24 Donation 25 Donation 25 Donation 25 Donation 25 Donation 25 Donation 25 June 24 Donation 26 Donation 27 Donatio	ine Fu	neral	Serv	ices
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		Dhusisian		23a. Pert1. Enter by disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arr	est,	Int	oproximate terval Between nset and Death
3	4	/Medical		Immediate Couse (Final disease or condition Necrotising factority)			6	monthy
	ı	Examiner	- A	Immediate Ceuse (Final disease or condition resulting in death) Necrotising facts ity. Due to (or as a consequence of):			i	
		outed nd ransit	Examiner	Sequentially list conditions Due to (or as e consequence of):			i	925
	90,	be executed sician end buriei-transit		Sequentially list conditions, if eny, leading to immediate ceuse. Enter Undertying Cause (Disease or righty)			i	8 months
	68760,	ing physi	edica	that inflieted events resulting in death) Lest Due to (or as e consequence of):	1 - 1			A
	Box	eeth certi ettending for use	an/M	a Protein deficiency maln	nmfr		6	mending
	P.O. E	the et	Physician/	Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I.				e cause of death?
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M	Records,	v require been sig should b	eted		24a. Wes a perform	n autopsy med?	comp	autopsy findings ble prior to letion of cause
A	Rec	ne law shesb age 2 s	Completed		10%	ss 2 No	of dea	ath? ′es 2□ No
,	ita	ysician: The l s certificete hi director, pege	Se l	25. Was case referred to medical examiner? 26. Place of Deat				55 22110
	of V	Physic this ce	٩	1 ☑ Yes 2 ☐ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho		ence 6 Other		
	no	oding F rth. : After e funer	ation	27. Menner of Deeth 1. ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury Bright Control of Injury Month Control o	25d. Describe III	ow injury occurred		
	Division of Vital	or Attending Physician: The law requires that the deeth certificate be executed efter deeth. Director: After this certificate has been signed by the ettending physician and in by the funeral director, page 2 should be deteched for use as the bunial-transit	Certification:	The same of the sa	28f. Location (Si City or Town	treet and Number n, Stete)	or Rural R	oute Number,
		ours ours filler	Saj Ce	29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place,				
		To the Hos within 24 h To the Fun completely	Medicai	(Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurrence and title of cartifier 29b. Signature and title of cartifier 29c. License number		ate and place, and		
		or with		29b. Signature and title of certifier D34974		march,	26.	2007
		(0)	}		2 1.15		0.10	7-
				30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Charumehta, MD 601, Southcharles Stock, 1 31. Date filed (Month, Dey, Yeer) 32. Registrer's Signeture	saltmo	re MD	1.612	ی ر
		Stat	е	ADD 1 0 2007				

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\(\) Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2007 **Physician** William Neal Shanks April 3:56 Рм /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford 6 Brooks Road Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 30, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1935 Months 1 M 2 □ F 213-30-5019 72 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show r 28a-f sh notified 1 ☐ Yes 2 X No Director Harford Bel Air Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. "natural", or Items 23a or 21014 6 Brooks Road USA by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 No 195
If Yes, Give
Year or Dates: 195 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1950 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 1952 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7 is marked other than traumatic event, the Me Manager Business Management 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Delora Hickman Cockrum Edgar Smith Shanks 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Kathleen A. Shanks, Wife 6 Brooks Road Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Tremation 3 Removal from State 04/09/07 Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Linensee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VENTRICULAR **Physician** LentyTMIN ELDNOS /Medical to (or as a consequence of) **Examiner** Sequentially not conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed OBALLD Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) signed by the a 9□Unknowr 9 Unknown 23e. Did tobaeco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No ate has bage 2 s 2 - No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No 20 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) Director; After that in by the funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral D

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

X

2

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who MIGGE

32. Registrar's Signature

2007 0

ompleted cause of death (Hem 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1- State Amend #20b, perFH, G866, 4/10/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2:1+h SENKER 2. Date of Death Month 3. Time of Death Year **Physician** 4.43AM April 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOWARD HOWARD COUNTY GENERAL HOSPITAL COLUMBIA 7. Age (In yrs. last birthday) 82 Yrs. 5. Social Security Number 081-18-8614 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/18/1925 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X** □ F Months Days Hours NY Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 1 ☐Yes 2√ No Funeral Director ELLICOTT CITY MD HOWARD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3300 NORTHRIDGE ROAD 21043 U.S.A. filed within 72 hours after death 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify 2 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. other than ' ent, the Me Elementary/Secondary (0-12) College (1-4or 5+) OWNER RETAIL Ith and Mental Hygie 27 is marked other I r traumatic event, th other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (CARMEL FLOME SADIE DAVID 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If item 27 any injury or other tr once. 4997 APRILDAY GARTH- COLUMBIA, MD 21044 SUSAN BARON ROBERTSON/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HEBREW 04/08/2007 WOODLAWN, MD 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PIKESVILLE, MD 21208 Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 1No Hospital or Attending Physician: Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannen of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation Injury nours after death.

neral Director: Af

v filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) completely and manner stated. 29b. Signature and title of certifier D30841 Back River Necle Road Baltimus MI)2124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sabepalm 20/-109 31. Date filed (Month, Day 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** ton Donna Lee Smith 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deat Examiner Franklin Baltimone tospita Se inve If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In vrs. last birthday **Funeral** Months 1 M 200 Director 219-52-4118 59 5, 1948 Maryland Apr. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Dunda1k 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7829 St. Fabian Lane 21222 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. I □ Yes 2 🟋 No f Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ William T. White Betty E. Keatts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7829 St. Fabian Lane Dundalk, Richard E. Smith (Husband) Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 4/10/2007 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 21222 7922 Wise Avenue fications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease, or come shock, or heart failure. List only of Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to r as a consequence of Examiner Sequentially list conditions, the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed burial-transi and Due to (or as a consequ Records, P.O. Box 68760 aftending physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an aw has autopsy performed Yes 2 certificate 1∐ Yes Division or Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 npatient this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 153 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical ompletely and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	or Maryland /		irtment of H tificate of l			Reg. No.	11309		
	Physici		1. Decedent's Name (First, Middle, Last) JANET SCITO	23.				2. Date of Dea Month APRIL	Day Year			
}	/Medio Examir		4a. Facility Name (If not institution, give street and	number) n	_	4b. City, Town, or	Location of Death			4c. County of Death		
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 X	7. Age (In yrs. last I	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth August 6,	9. Bi	rthplace (State or Foreign ountry NSVIvania		
	a-f ehow	ctor	Usual Residence of Decedent 10a. State Virginia Albemarle	10c. City, To		cation				10d. Inside City Limits 1 ☐ Yes 2 🕅 No		
	h with th	al Director	10e. Street and Number Mary Mart Farm Roa	d		10f. Zip Code 22932			log. Citizen of What C USA	ountry?		
920	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Deperment of Health and Mental Hygiene. Important: if item 27 te marked other than "natural", or iteme 23e or 28e-f ehow enty injury or other traumatic event, the Medical Exacting could be rightled at once.	by Funeral	1 Never Married 2 Married 1 Yes	Decedent Ever in U.S. 1 Forces? es 2 No Give or Dates:		Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🛣 No	spanic Origin? (Sin, Mexican, Puert Specify:	Decify Yes or No- Decify Yes or No- Decify Yes or No-	14. Race - Am Black, Whi Specify:Wn1	ite, etc.		
21215-0036	Jwithin 72 ho liene. r than "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Colleg 2	ed) le (1-4or 5+)	(Give I life. [ent's Usual Occupa kind of work done of NOT use retired Hygenist	ition fu <i>ring</i> most of wor)	1	16b. Kind of Business Dentist Office			
land ?	id be filed ental Hygi ked other ic event, I	To Be C	17. Father's Name (First, Middle, Last) Thomas Fielding Scholes	1					Maiden Sumame)			
Maryland	and 2 should eaith and Men n 27 te marke er traumatic	-	19a. Informant's Name/Relationship (Type, Print) David Hart/Son			g Address <i>(Street a</i> est Lanvale			r, City or Town, State, aryland 212			
Baltimore,	Pages 1 and neut of Heisant: if item		20a. Method of Disposition 1 ☐ Burial 2 ◯ Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)			ition (Name of atory or other place Vice Corp.	4/1		20c. Location - City of Towson Mary 1			
Balt	permit. Page Depertment of tmportant: if eny injury or		21. Signature of Funeral Service Licensee Churstina L. Hel	ton	1 6 5 5	Name and Address onard J. Ri 805 Hartord	s of Facility ICK Inc Road Ball	timore Mar	yland 21214			
68/60,	hysician be executed by the purial-fransit as the burial-fransit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	to (or as a consequence	Of.	PSM2h W				Approximate Interval Between Onset and Death		
O. Box 6	requires that the death certific seen signed by the ettending p hould be detached for use as	Physician/Me	in the past 12 months?	outcome of pregnancy ve birth 2 Fetal dea egnant at time of death iknown		Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year		
J	w requires that been signed b should be deta	Ď	Part II. Other significant conditions contributing t	o death but not resulting	in the un	derlying cause give	n in Part I.	23e. Did tol	bacco use contribute to	o the cause of death?		
al Records	The law ate has b page 2 s	Completed						24a. Was a autops perform	ry prior to death?	utopsy findings available completion of cause of s 2 □ No		
or Vital	S 50	To Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital:	Inpatient 2□ER/C	utpatient	3□ DOA Othe	r.	th <i>(Check only on</i> ome 5 ☐ Reside	e)ence 6 □Other (Spe	эcıfy)		
DIVISION	Attending Ph r death. ector: After th by the funeral	Certification:	2 ☐ Accident investigation	ate of Injury 28b.	Time of Injury	28c. Injury Work M 1 \(\supers	at ? ′es 2 □ No	28d. Describe ho	ow injury occurred			
	To the Hospital or Attending within 24 hours effer death. To the Funaral Director: After completely filted in by the fune		4 Homicide determined by	ace of Injury - At home, illding, etc. (Specify)				City or Town	,			
	To the Hosp within 24 hor To the Funa completely fi	ledical		the best of my knowledge basis of examination a anner stated.	ge, death ind/or inv	estigation, in my op	inion, death occui	and due to the cared at the time, d	ause(s) and manner a ate and place, and du	s stated. a to the cause(s)		
,	To will	Σ	29b. Signature and title of certifier	ATTELLO				Å	9d. Date signed (Moni	th, Day, Year)		
5	,		30. Name and address of person who completed of J. NAZARA W. M.	301		Paul 8	T. Be	ltimore	, 21201			
	Sta Registr		31. Date filed (Month, Day, Year) / 33	. Registrar's Signature	di y	Lands						

07-02279	

Pavid L. Spence		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.	3
Physici: Medical Exami		1. Decedent's Name (First, Middle,Last) David L. Spence 2. Date of Death Month Day Year March 24, 2007 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death	
Funeral Director		1477 West Key Parkway 5. Social Security Number unk 1 X M 2 F 7. Age (In yrs. last birthday) 5.5 Yrs. 7. Age (In yrs. last birthday) 5.5 Yrs. 8. Date of Birth (MM/DD/YYYYY) Min. 9. Birthplace (State of Boreign Country)	oʻunk
Varyland 28a-fshow any d at once.	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City MD Frederick Frederick 1	
with the Maryland ms 23a or 28a-f sho be notified at once	I Director	10e. Street and Number 1477 West Key Parkway 21702 USA 11 Marital Status UNK 112 Was Deceded Floring US 14 Marital Status	
2 hours after death "natural", or ite LExaminer must	eted by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes 2 No specify 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of work donank during most of working life. DO NOT use retired) 17. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 18. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 10. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Yes 2 X No specify 12. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work donank during most of working life. DO NOT use retired) 16b. Kind of Business/Industry	unk
5-003(led within Hygiene other tha	Be Completed	unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname)	unk
MD nd 2 sho alth and m 27 is	Tof	19a. Informant's Name/Relationship (Type, Print) O.C.M.E. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD 21201 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State	
Balt permit. Departi Import		21. Signature of Funeral Service Licensee Ronald S. Made, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate	
Physician /M Examiner	3 3	failule. List only one cause on each line. Immediat Cause (Final disease or condition resulting in death) Between Or Deat Due to (or as a consequence of).	nset and
d Sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
60, ate be executed hysician and e burial - transit	edical	d. X UNPENDED AMENDED #23a,27,per/ME,g867,5/4/07 TT IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery	
Sion of Vital Records, P.O. Box 6876 (Attending Physician: The law requires that the death certificate death. ector: After this certificate has been signed by the attending phy. by the funeral director, page 2 should be detached for use as the b	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Y 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	′ ear
ds, P.O. equires that the cen signed by tould be detached.	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Ur 24a. Was an 24b. Were autopsy findings	nknown available
of Vital Records, ng Physician: The law require After this certificate has been si meral director, page 2 should b	e Completed	autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 25. Was case referred to medical 26. Place of Death (Check only one)	ause of
n of Vital ling Physician: After this certif	n: To B	examiner? 1 Ves 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
돌 e e e e e e e e e e e e e e e e e e e	Certification:	1 X Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) 1 Yes 2 No 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Num or Town, State)	ber, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical Ce	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	2	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) March 25, 2007	
	tate	Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Regis	trar	APR 1 0 2007 1000 15 1000	
DHMH 17 Rev 1/2 OCMF 2006	:001	ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 200 T /Medical 4c. County of De Gilly Nam (If not institution, give street and number) or Location of Death Examiner)Ohns MILLERG If Under 24 Hrs. last birthday)
Yrs. 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 8. Date of Birth Month, Day, Year) **Funeral** Days Min 1 M 2□ F Director Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Director lan 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code a or 7 Is marked other than "natural", or Items 23a traumatic event, the Medical Examiner must b Funeral 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No <u>^</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within than dental Hygiene.
7 Is marked other than "I Kakes Elementary/Secondary (0-12) College (1-4or 5+) Laborer 17. Father's Name (First, Middle, Last) Be 1 eon 1 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health 6 Important: If item 27 Is any injury or an 1 and 2 s Health ar Davis 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Odays /Medical stavascular Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burial-tran and Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?

1 \(\sum \) Yes 2 \(\sum \) No

9 \(\sum \) Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 ☐ Unknow ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 1 🗌 Yes 2 No 3 Probably 4 ☐ Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy 2 No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2XI No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natura 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours af Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2. 29c. License number dress of person who completed cause of death (Item 23a) (Type, Print) Spermeter The Johns Hopeins Hospital, 600 North wolfe Street, Bellimore, Mary know, 21287 31. Date filed (Month, Day, Year) State Registrar

7,1			Johnson (10, 203)
State of Maryla	nd / Denartment of	Health and M	ental Hygiene

			1- State of Maryland / Department of Health Certificate of Death			IENE U U / og. No.	11016
ı	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Deat Month		3. Time of Death
	/Medic	al	Ossie Tate Sr.		4	8 2007 Year	
	Examin	er	4a. Facility Name (If not institution, give street and number) Chapel- Hill Nursing Home 4b. City, Town, or Location Randallsto			4c. County of De	imore
1	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under		8. Date of Birth		inthplace (State or Foreign Country)
	Director		224-01-0734	s Min.	8. Date of Birth (Month, Day, 8-16-1	917	N.C.
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Mary I sho	tor	MD Carroll Sykesville				1 □ Yes 2X No
	or 28s	Director	10e. Street and Number 5610 Rhonda Road 217	7.0 /-	1	0g. Citizen of What 0	Country?
	death with the Maryland ms 23a or 28a-f show rmast be notified at	ral				USA	
_	be filed within 72 hours after death with the Marylan ital hygiene. d other than "natural", or itams 23a or 28a-f show event, it a Marksal Exprimer must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married	Origin? (Spec can, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	ite, etc.
0030	hours after tural', or ita	þ	1 ☐ Never Married 2 ☐ Married 1 ☒ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☒ No Specify Year or Dates:	ity:			rican- merican
	72 ho	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during mo	ost of workin	ıa la	16b. Kind of Busines	
C1212	within 72 ene. than "nai	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Coal Miner		.9	_	ille Coal
-	filed Hygie		6th 17. Father's Name (First, Middle, Last) 18. Mott	ther's Name	(First, Middle, M	C (Maiden Surname)	Ο.
yland		To Be			Chamb	•	
Mary	2 should and Men is marke sumatic		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number and Nu</i>				
e, ≅	s 1 and 2 should f Health and Mer ltam 27 is marke other traumatic		Ossie Tate Jr. / Son 5610 Rhonda Roa			· · · · · · · · · · · · · · · · · · ·	
	ages in the state of the state		20a. Method of Disposition 1 ◯───────────────────────────────────	!	·	20c. Location - City o	
Бащто	permit. Pages Department of I Important: If It any Injury or of	_	4 □ Donation 5 □ Other (Specify) Loudon Park Cem. 21. Signume of Funeral Service Licensee 22. Name and Address of Fact	cility Wv 1	ie F/F	Baltimon	re, MD F Balto, Co
ñ	Per Imp Pop Onc	il i	Mandou M. Wyle 9200 Liberty				
	6		23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.	as cardiac or	respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. END STACE DENENT	1A			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				
34 3	X	e	Sequentially list conditions, if any, and in the immediate cause. Enter Underlying Cause (Disease or injury				
	cuted nd ransit	Examiner	that initiated events				
Č	oe exe		resulting in death) Last Due to (or as a consequence of):				
00/00	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edical	d.				-
Š	nding use a:		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of de	alivery
0	death	Physician/M	in the past 12 months? 1 Yes 2 No 1 Yes 2 No			Month	Day Year
<u>r</u> 5	at the d by the	Phys	9 Unknown		T		
ń	The law requires that the death cer ite has been signed by the attendin page 2 should be detached for use	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	rt I.			to the cause of death? Probably 4 KUnknown
cords,	w requ	letec			24a. Was ar		
ב ב	hysician: The law his certificate has t I director, page 2 s	Completed			autops	y prior to ned? death?	
		BeC	25. Was case referred to medical 26. Plac	ice of Death	Check only one		s 2 No
> 5	Physic this ce	၉	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 No	Nursing Hom	ne 5□Reside	nce 6 □Other (Sp	ecify)
=	ding F	tlon:	27. Manner of Death 28a. Date of Injury 28b. Time of Scholary 2 □ Accident investigation 28a. Date of Injury 28b. Time of Injury 48c. Injury at 1 □ Yes 2 □		8d. Describe ho	w injury occurred	
NISIO I	Attender death	flca	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office		8f. Location (Sti	eet and Number or F	Rural Route Number,
5	s afte	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town	, State)	
	To the Hospital or Attending Physicien: which 24 hours after deals at the funeral Director: After this certification to the Funeral Director: After the funeral director, completely filled in by the funeral director,	Medical	29a. Certifier (Check only a Medical Examiner: On the best of my knowledge, death occurred at the time, date a complete of the	and place, ar	nd due to the ca d at the time, da	use(s) and manner a	as stated.
	o the o the omple	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number			d. Date signed (Mor	
	- 5 - 6		11(1) K.S. NAS. M.D D434	162		PRIL 9	
10	+		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K S NAO				
W	01		Jyoo OLO COURT PA #108 Randallytoo	3, 00	10 2	11.2.3	
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend PI, 25,27,28a-f, perME, g867, 50 of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** James Tracey 4:59 PM 2007 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore NIA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**X** M 2 □ F Director 214-72-9999 49 9/25/1957 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show be notified at Director MD BALTIMORE TOWSON 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 1690 YAKONA ROAD or items 23a 21286 USA must 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or items edical Examiner n Black, White, etc. 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 ☐ No Specify: ò 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I any Injury or other traumatic event, the Med ginee. Elementary/Secondary (0-12) College (1-4or 5+) 8TH GRADE MACHINIST MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES R. TRACEY, SR. SYLVIA MAHANEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHLEEN A. TRACEY/ WIFE 1690 YAKONA ROAD TOWSON. MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/7/2007 | CATONSVILLE, MD METRO CREMATORY, INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Liver failure Secondary to Tylenolobus and alcohol 5 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION AND PROVED BY HEDICAL EXAMINER Examiner Due to (or as a sunsequence of): requires that the death certificate be executed burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the ! as 1 IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) __ for in the past 12 months? Month Day Year 1 ☐ Yes 2 ☐ No. s been signed by the should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by tailure 1 Tes 2 No 3 Probably 4 Unknown regulring 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe certificate 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 XYes - 25XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending _investigation 1 Natural Injury 1 ☐ Yes 2 No within 24 hours after death. 2 Accident unk unk unk 6 X Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide ŏ unk unk 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P 3 MD A 44176435K15869 104/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stacy 21201 22 S. Greene Street, Baltimore, MD Kennedy MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			For State		State of	f Marylar		artment e <i>rtificate</i>				lental Hy	9	007	11316
			Registrar 1. Decedent's Name (F.	irst. Middle. L	ast)			Tillicale	OIL	Jeani		2. Date of De	Reg. No. C.	007	3. Time of Death
	Physici		Donald T		,							Menth	1 Day 09	200	, 553 am
	/Medi Examir		4a. Facility Name (If no		ve street and nun	nber) 1	/ 0	4b. City, To	own, or	Location	of Death	1	4c. Col	unty of Death	
			Maryla.	nd Gre	eneral,	HOSPi	tal	Bal	for	ore	Cr	fy			
	Funeral		5. Social Security Numb		Sex 1MM 2□F	7. Age (In yrs.		/) If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth ay, Year)	9. Birthp	olace (State or Foreign
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	land			b. County	-	10c. Ci	ty, Town or I	ocation							Od. Inside City Limits
	Mary -f she	ţ	MD				В	altimo	re						1 Yes 2□No
	r 28a r notif	Director	10e. Street and Numbe	r				10f. Zip C	Code]	10g. Citizen	of What Cour	ntry?
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		Funeral	11. Marital Status		12. Was Dece Armed For		unk 13	. Was Decede If Yes, specif	nt of His	spanic Or n, Mexica	igin? (Spen	ecify Yes or No Rican, etc.)	0- 14.	Race - Americ	
% S	s afte	by F	1 ☐ Never Married 3 ☐ Widowed 4 ☐	_	1 ☐ Yes If Yes, Giv	2 □ No e		1 ☐ Yes 2		Specify.				ecify: bla	
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Jonal	permit. Pages 1 Department of H Important: If ite any injury or ot		1 ☐ Burial 2 ☐ C	remation 3	Removal from S	state	cemetery, cr	oosition (Name ematory or oth	ner place	9) :		outo	200. Eocati	on - Ony or Te	Jwii, State
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	Examir		4a. Facility Name (If not institution, give				4b. City	, Town, or	Location of	of Death			ounty of Death		
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	Funeral Director		5. Social Security Number 6. Se 11 212-28-4955 Usual Residence of Decedent	X 7. A XM 2□F	74	ast birthday) Yrs.	If Unde Months	Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, 09/03/1	^{Year)} 932	ear) 9. Birthplace (State or Foreign Country) Maryland		
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e,	Healt Pm 2 ther		Betty J. Von Hage 20a. Method of Disposition	I (Spouse		」 546∠ lace of Dispo			1 Road		altimore		rytana tion - City or To		
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8	or us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1□Live birth	2 Fetal	death 3	Ectopic p					23d	 Date of deliver Month 		'ear
O. Box	the c	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	at time of de	eath 5∟	Other (s)	oecify)			·			,	
<u>a</u> . §	ed by detac	P.	Part II. Other significant conditions co	ntributing to death	but not resu	ilting in the u	nderhijna (Called and	o in Part I		23e Did toba	CCO USA	contribute to the	he cause of de	nath?
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7	14/		30. Name and address of person who of	mpleted cause of	death (Item	23a) (Type,	Print)	ri	Crust	E 21	4. BERTI	none	no.	uu7	
	Sta	to	31. Date filed (Month, Day, Year)	32. Redict	trar's Signat	ure			8	-) (, , , , , , , , , , , , , , , , , , , ,				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:30 AM Isabelle Watson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner 200 First Avenue, Apt. ansdowne Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unde Hours Davs Months Min. 1 ☐ M 2 🗓 X F 233-50-9786 1919 | West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2√☐ No Director Lansdowne 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 200 First Avenue, Apt. 211 21227 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: White þ Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Housekeeper Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ezra Griffith Ida Turner ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2708 Berwick Avenue, Baltimore, MD 21234 Catherine Zink - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Aakeview Memorial 20a. Method of Disposition 20c. Location - City or Town, State W Burial 2 ☐ Cremation 3 ☐ Removal from State 4-9-2007 4 □ Dopation 5 ☐ Other (Specify) Sykesville, MD Park Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Examiner dury, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ 146 24a. Was an was autopsy performed as 2 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 TYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Iniury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined

burial-tran P.O. Box 68760, physician pe the use as t attending for signed by the a d be detached for Division or Vital Records, page 2 should has certificate

funeral director, After this Certification: e Hospital or Attending 24 hours after death. To the Hospital or Attend within 24 hours after death To the Funeral Director; the

Funeral

Director

r 28a-f show notlfied at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be n

Physician /Medical Examiner

3altimore, Maryland 21215-0036

State Registrar

Medical

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

31. Date filed (Month, Day, Year)

APR 1 0 2007

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

00 GeipeRd, Castonsville MD Z1228

_			1 - For State Registrar	State of M	Marylar				lealth a		ental Hyg	iene	07	11317	
	Physici	ian	Decedent's Name (First, Middle, La		1		-				2. Date of Deat	Day 2	Year	3. Time of Death 4: 20 A . M.	
	/Medi	cal	Bartow W. 4a. Fecility Name (If not institution, given		ooden	•	Jr.	Tour	r Location o	of Dooth	Ariou		y of Death	4,204 .M.	
	Examir	ner	Baltimore Washing			nter			urnie			de 1			
	Funeral		5. Social Security Number 6. S	Sex 7.		last birthday)	If Unde	r 1 Year	If Under	24 Hrs.	8. Date of Birth	Anne		place (State or Foreign htry)	
	Director		201 44-1072	[X M 2□F	78	Yrs.	Months	Days	Hours	Min.	Month, Day,		Cou	FL	
_	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation						-	10d. Inside City Limits	
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		Funeral Director	11. Marital Status	12. Was Decede Amed Force	s?	.S. 13.	Was Dece If Yes, spe	dent of Hi	ispanic Origin, Mexican	gin? (Spec	cify Yes or No- Rican, etc.)		ce - Ameri	can Indian, etc.	
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5	hin 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4c	or 5+)	(Give	kind of w DO NOT i	ork done d ise retired	during mosi d)	t of workin	g			•	
2 5	be filed within that Hygiene.	S		4	.,	Se1f	Emp1	oyed				Couri			
33	tati H d oth	Be	17. Father's Name (First, Middle, Last								(First, Middle, A	Aaiden Sumai	me)		
- 2	hould d Men narke	2	Bartow W. Wooden 19a. Informant's Name/Relationship (10h Mailie	n a Addess	- /54-0-4			ndberry Route Number,	City on Town	Ctata 7	Codel	
BARTOW WOODEN	ges 1 and 2 should be filed wit to f Health and Mental Hygien. If item 27 is marked other th.		Valeria Washingto		ter		-				pér Mar	•		·	
20 5	thea thea other		20a. Method of Disposition		20b. F	Place of Dispo	sition (Na	me of		April	-	20c. Location			
A S	Page nent o		1. Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		TO	-	•			200		Baltim	ore.	MD	
3ARTOW	permit. Pages Department of I Important: If its eny injury or of		21. Signature of Fine/al Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A												
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			23a. Part . Enter he disease, or com shock, or h art failure. List only	plications that caus one cause on each	sed the deat n line.	h. Do not ent	er the mo	de of dying	g, such as	cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death	
	Physician /Medical	10 1	Immediate Cause (Final disease or condition resulting in death)	a Choi	111	upsda	eter	e f	Ju/n	mou	dis	case	-	Chisot and Death	
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9		EX	resulting in death) Last	Due to (or a	as a conseq	uence of):									
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<u> </u>	The law requires that the death certific to the law requires that the death certific the been signed by the attending page 2 should be detached for use as:	Physician/Med	IF FEMALE:	23c. If yes, outcom	ne of pregna	ancv						224 D	-46 deli:		
B S	eath atten	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1□Live birth	2 Fete	ldeath 3□	Ectopic p						ate of delive onth	ery Day Year	
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<u>.</u>	es that igned to be det	by P	Part II. Other significant conditions of	contributing to death	n but not res	ulting in the u	nderlying	cause give	en in Part I.		23e. Did tob	acco use con	tribute to t	he cause of death?	
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Ċ	rs effe	Cert	Tomicas	building,	etc. (apecii	y) 					City or Town	, 3(4(8)			
	To the Hospital or Attenwithin 24 hours effer deatl To the Funeral Director: completely filled in by the	edical Certification:	29a. Certifier 1 Certifying Pt (Check only 2 Medical Examone)	nysician: To the be miner: On the basis and manner	of examina	wledge, death	n occurred vestigation	at the time, in my op	ne, date and pinion, deal	d place, at th occurre	nd due to the ca d at the time, da	use(s) and m ite and place,	anner as s	tated. the cause(s)	
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			A A A		W	M		14	397	7		and a	5 7	2007	
•	\mathcal{Y}		30. Name and addre is person who	completed cause o	f death (Iten	23а) (Туре	Print)	N	1	D -	``	1 1			
	0		Choken Stepm	n. 301	HARD-	TM)	notes	, U	len	BUN	nl (ms	2,00	t.	
	Sta Registi		31. Date filed (Month, Day, Year)	32. Hegi	strar's Signa	iture	Can Alle A	i							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2:25 P M Alan Douglas Waggoner 2007 April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Center Baltimore Towson If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 407-86-0061 46 Director 1960 Sept 8, Kentucky Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examiner must be notifiled 1 ☐ Yes 2 No Director Maryland Anne Arundel Odenton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with Hygiene.
ther than "natural", or items 23a or 384 Mount Vernon Avenue 21113 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 27 No If Yes, Give Year or Dates: 1 ☐ Yes 27 No Specify: Specify: White <u>Ş</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Flight Attendant Air Travel and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harold Kermit Waggoner Hettie Bernice Hall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trauonce. 2249 Mangrove Drive Lexington, KY 40513 Mark A. Waggoner, Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 04/09/07 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee

Thomas Gregor 2. Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 1ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause () is also of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and burial-trar Due to (or as a consequence of): physician Physician/Medical the as attending IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 No 3 | Probably 4 | Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → No 24a. Was an Was a... autopsy performed? Ves 2 1 No has page 2 certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Sether (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ After this funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 M Natural Injury thin 24 hours after deaun.

o the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, o ٦ Division or Vital Records, death certificate be executed

3altimore, Maryland 21215-0036

Pages 1

To the within 2 2

Hospital or Attending

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

mo

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1)006/19

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

April, 8, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Black 6565 North Charles ST, Suite 209. Touson, MD 21209

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #7 Per FH C866 4/18/07 JH Certificate of Death Reg, No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Elena Marquerite Williams <u> April</u> 2007 20:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ▼ F 90 87 Director 216-30-1309 27, 1916 Italy Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits show la or 28a-f sho t be notified a 1 ☐ Yes 2 ☐ No Director Maryland | Harford Joppatowne 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? ms 23a must b 239 Kearney Drive USA 21085 Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married timore. Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Completed by 3 NWidowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic event, the Medical College (1-4or 5+) Elementary/Secondary (0-12) Press Operator Charitable Organization marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fil Health and Mental H tem 27 Is marked ott Be ပ (unk) (unk) Faleschini (unk) (unk) (unk) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Terry G. Williams / Son 423 Campus Hills Drive, Bel Air, Maryland 21015 other t permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 4-6-07 Towson, Maryland 21. Signature of Funeral Service Rigens 22 Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Anoxic encertableathy **Physician** /Medical Due to (or as a consequence of): 30 hrs **Examiner** Cardiac arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Physician/Medical Examiner Due to (or as a consequence of). IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an was an autopsy performed?
Yes 2 No page 2 No Vital 1☐ Yes 1 Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To 2 ER/Outpatient 3 DOA 5 this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 ☐ Pending investigation 4 hours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ပ 00063420 April, 1,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Upper Chesapacke Dr. Bel Air, MD 21014 Zubair Khara 1 500 U

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

PNR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0738 A M Deborah Ann Windhorst Apri 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner baltmor If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6 Sex Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🔀 F Yrs. Director 220-78-9799 Usual Residence of Decedent 22, 1956 50 Maryland Aug. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 √Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 South Athol Street 21229 United States Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5 vears Disabled N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic evance. David Windhorst Kay Francis ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2111 Presidential Pkwy., Unit 24, Twinsburg, Ohio Bobbi Williams (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 4/11/2007 Towson, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocwolia whown /Medical Due to (or s a consequence of) Examiner Sequentially list conditions, it is a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Vear 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 1 ☐ Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 □ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury To the Hospital or Attendil within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 047353 2007 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltwore, Mary land

State

Deboral

31. Date filed (Month, Day,

32 Registrar's Signature

Registrar

			For	State of	of Marylar		artment of H			ntal Hyg	iene	C (2) 22	1 1 0 /	0.1
			1 - State Registrar			Cei	rtificate of	Death		Re	eg. No	<u>'UU/</u>	113	<u> </u>
н	Physici	an	1. Decedent's Name (First, Middle	, Last)					2.	Date of Deat Month	h Day	Year	3. Time of Dea	ath
	/Medic		Patrick Thomas							April 3		007	2:30 p	M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death								4c. C	ounty of Death		
			Gilchrist Cent 5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	Towson		24 Hrs. 8.	Date of Birth	Ba	altimore		
И	Funeral Director			1 M 2 □ F		Yrs.	Months Days	Hours	Min.	(Month, Day,		Coun	21	oreign
4ú	dijid.		212-56-2630 Usual Residence of Decedent	Λ	56				Ai	ıg. 12,	, 195	00 Mary	land	
	ylanc ylanc		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation					1	0d. Inside City L	imits
	a-f sl	ctor	Maryland Bal	timore		Dundal	.k						1 □ Yes 2 □	No
	or 28	Director	10e. Street and Number				10f. Zip Code			1	0g. Citize	en of What Coun	try?	
	23a ust b		1930 Midland F	load			2122	2			Unit	ted Stat	es	
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Funeral	11. Marital Status	Armed F		J.S. 13.	Was Decedent of H If Yes, specify Cub	fispanic Or an, Mexica	igin? (Specif n, Puerto Ric	y Yes or No- can, etc.)	14	 Race - Americ Black, White, 		
36	s afte	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, G	2X No ive		1 ☐ Yes 2 🖾 No	Specify:	:		s	Specify:		
5-003	hour tural	a be	15. Decedent	Year or E	Dates:	16a Dacar	dent's Usual Occup	agtion		-	16b Kind	Specify: Whit of Business/Ind	e	
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g	illec I Hyg other	Be C	17. Father's Name (First, Middle,	Last)						irst, Middle, N				
Maryland	should be filed within 72 hours after death with the Marylan to Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	To B	Richard Welsh					Ruth	Mav F	Revnold	ls			
a	2 should I and Men Is marke aumatic		19a. Informant's Name/Relationsh	nip (Type. Print)		19b. Mailir	ng Address (Street					Town, State, Zip	Code)	
	# 2 # ud		Jocelyn Welsh	(Wife)		1930	Midland :	Road	Dunda	alk, Ma	ryla	nd 2122	2	
altimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	2 Domoval from		Place of Dispo cemetery, crei	sition (Name of natory or other pla	ce)	Date			ation - City or To		
Ĕ	tnent of l tant: If it		4 □ Donation 5 □ Other (S			k Lawn	Cemetery	1	4/10/2	2007	Balt	imore,	Marvland	Ē
gall	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	Licensee		22 D	Name and Addre	ss of Facili	ral Ho					
_	90 E 8 9		Selfa			7	922 Wise	Aven	ue Dr	ndalk,	Mar			
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deal each line.	th. Do not ent	er the mode of dyir						Approximate Interval Betwee Onset and Deat	n
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	/Medical Examiner	Н	robating in doubly	Due to	(or as a consec	quence of):		1					0	
		e.	Sequentially list conditions,	b. Due to	(or as a curisso	Juence ofk								
	uted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury		,	,								
5	execting and and ial-tra	Еха	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):				<u> </u>				
2/6U	ficate be executed physician and s the burial-transit	dical		d										
9	tifica ng phy as th	Medi						_						
X Q Q	w requires that the death certifi been signed by the attending I should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	itcome pf pregn		Ectopic pregnanc	v			23	d. Date of delive	,	
	e dea he at ied fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of		Other (specify)	,				Month	Day Year	
л Э	requires that the	Phy	9 ☐ Unknown Part II. Other significant condition			and the second second	4-4-4	5. (1		00 - D:41 I				•
Ś	ires the signer of the d	þ	Fait ii. Other significant conduct	ns contributing to a	ream but not res	sulung in the ul	idenying cause giv	en in Part i	.		acco use s 2□	e contribute to th		
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Hecord	e law has be	ompleted								24a. Was ar autops	v	24b. Were autoprior to cor	osy findings avai npletion of cause	lable of
	r: The licate har, page	O								perford 1 Yes 2	No	death? 1 ☐ Yes	2 □ No	
VITAI	Physician: The law this certificate has k al director, page 2 s	o Be	25. Was case referred to medical examiner? 1 ☐ Yes No	Hospital:	Inpatient 2 □	TER/Outrotion	t 3 DOA Oth	or.		heck only one			Laco/	· C
0	ding Phys	一曲	27. Manner of Death	28a. Date	of Injury	ER/Outpatien 28b. Time of	· OLI DOX	4 L NE		5 Reside Describe ho		Other (Specify	HOSM	
VISION	Attending r death. ector: After by the fune	tio	1 Natural 5 Pending 2 Accident investig	9	nth, Day Year)	Injury		k? Yes 2 🗌						
N N	after death after death Director: /	ifica	3 Suicide 6 Could n 4 Homicide determi	nod 280, Place	e of injury - At h	ome, farm, str	eet, factory, office		28f.	Location (Str	reet and I	Number or Rura	Route Number,	
5	s afte al Dir	Certification:	4 El Homoldo	Dullo	ing, etc. (opecin	·y/				City or Town	, State)			
7	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier Certifyin (Check only one) Medical I	g Physician : To the Examiner : On the band man	e best of my kno casis of examina nner stated.	owledge, death ation and/or in	n occurred at the til vestigation, in my o	me, date ar opinion, dea	nd place, and ath occurred	due to the ca at the time, da	ause(s) ar ate and p	nd manner as st lace, and due to	ated. the cause(s)	
(h)	Total Communication	Ň	29b. Signature and title of certifier	e RI	acel	les	D 29c. Licens	e number 564	H3	25	9d. Date (signed (Month, I	Day, Year)	
6)		30, Name and address of person of the state	who completed cause	se of death (Iter	m 23a) (Type,	Print)	con E	Slud/	Balte	2 M	D 21	204	
F N	Sta Registr	_	31. Date filed (Month, Day, Year)		Registrar's Signa	ature	perte							
			2.24.23 mm		4 -									

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State of Maryland / Department of Health and Mental Hygiene 2007 11322

		1- For State Registrar	Certificate d	of Death		Re	eg. No.		
Physicia	ın/	Decedent's Name (First, Middle,Last)	-			Date of Deat Month		3. Time of Death	
edical Exami		ANDRFW J 4a. Facility Name (if not institution, give street and number)		YOUNG			07 4c. County of Dea	1023 hrs	
#	Ocean Gateway & Buck Bryan Rd			4b. City, Town, or Location of Death Trappe			Talbot		
Funeral			e (In yrs. last birthday)	If Under 1 Ye		⊣	1	irthplace (State or	
Director		040-38-1012 1XM 2 F	51 _Y	months Day	s Hours Mir	1/14/	1956 Fore	country) CT.	
any	-	Usual Residence of Decedent 10a State 10b, County	10c. City, Town or Loc	ation				10d. Inside City Limits	
. § .,₁								1 Yes 2 No	
Aaryland 28a-f show Lat once	Director	NY PUTNAM 10e. Street and Number	MAHOCPA	Mahopac 10f. Zip Code		10	Og. Citizen of What Co	۸	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mendal Hygienei min 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-fahr matic event, the Medical Examiner must be notified at once		231 WIXON POND ROAD		10541			U.S.A.		
th with	era	11. Marital Status 1 Never Married 2 X Married Armed Forces?	Ever in U.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	- 14. Race - Ame White, etc.	erican Indian, Black,	
er dea	Fun	3 Widowed 4 Divorced If Yes, Give Year	X No		specify:		Specify:		
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a a a a		PETER COLLINS / ATTORNEY 20a. Method of Disposition	9 FA	IR STREE	- CARME	L N Y	10512 20c. Location - City of	or Town State	
2 8 2 2 8		1 X Burial 2 Cremation 3 X Removal from Sta	ate crematory or	other place)	04	/06/2007	1	. Tomi, olato	
Baltimo permit Page Department or Important: injury or oth	1	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	BETH ISRAI	LL Name and Addres	s of Facility	SOL LEV	AVON, CT. INSON & BR	OS INC	
Dep Dep	, ide	Scott M. atter		8900 REI	STERSTON	IN ROAD	- PIKESVIL	LE, MD 21208	
Physician // /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and							
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a conse						Death	
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	iner	if any, leading to immediate Due to (or as a consequence of):							
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760, icate be ex physician the burial	Medical	UNPENDED AMENDED PET AMENDED PET AMENDED 23c. If yes, outcor	FH, g866, 4/1	LO/07 TT			23d. Date of delive	ery	
Ox 687 ath certifica attending p	ician/I	23b. Was decedent pregnant in the past 12 months?	2		Ectopic pregn	ancy	Month	Day Year	
Box 68 e death certif the attending	hysic	1 Yes 2 No 9 Unknown 9 Unknown	time of death 5	Other (Specify)					
P.O. Es that the d	by Ph	Part II. Other significant conditions contributing to deat	h but not resulting in the	e underlying cause	given in Part I.		bacco use contribute		
S, P.C uires that n signed l								obably 4 Unknown	
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n of V ding Phys After thi funeral d	5	27. Manner of Death 28a. Date of Inju	iry 28b. Time o		ury at Work?	28d. Describe	how injury occurred		
Sion Attendin or death.	tion	1 Natural 5 Pending Pround Apr 4, 2007 Natural 5 Pending Pround Apr 4, 2007	FOUND: 1023 hrs	1	Yes 2 🗸 No	Passenger	in plane crash		
Division of Vital Records, rat or Attending Physician: The law requires after death. In Director: After this certificate has been seled in by the funeral director, page 2 should it.	Certification:	3 Suicide 6 Could not be 28e, Place of Ir	njury - At home, farm, st	reet, factory, office	building, etc.		Street and Number or l State) yay & Buck Bryan Ri	Rural Route Number, City	
ospital hours uneral y filled		4 Homicide determined (Specify) Fig. 29a. Certifier 1 Certifying Physician: To the best of m			data and olana an	,			
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certifi within 24 Hours after death. with 124 Hours after death. or the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) 2 Medical Examiner: On the basis of exa	mination and/or investi	gation, in my opinio	on, death occurred	at the time, date	and place, and due to	the cause(s)	
To To	Me	and manner stated. 29b. Signature and title of certifier		29c. Licer	nse number		29d Date signed (A	Month, Day, Year)	
,		SHClark M		0.0	,M.E.		April 5, 2007		
2.5		30. Name and address of person with completed cause of a		onn Street B-	Itimore MD 2	1201			
200		Susan Hogan MD. Assistant Medical E 31. Date filed (Month, Day, Year) 32. Registra	xaminer 111 Po	enn Street, Ba	iumore, NID 2	1201			
S Regis	tate		Sales Signature	22346					

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nysician	Registrar 1. Decedent's Na	ıme (First, Middle,	Last)		Uel	tificate of	Dealii	2. Date of De	Reg.	No.	3. Time of Death						
tical	G I D			E W S				Month		27, 2007	7:30 A						
niner	4- 5- 25- 11-		give street and numbe			4b. City, Town, o	r Location of Deatl			4c. County of Death							
	SALISBUE		& NURSI			SALISBURY, MD.				MICOMIC							
	5. Social Security 212-10-4 Usual Residence	1443	5. Sex 1 □ M 2]X] F	nge (In yrs. 89	last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di Octobe	rth ay, Ye	9. Birthpl Count 26,1917 Mar	ace (State or Fore ry) 'yland						
	10a. State	10b. County		10c. Ci	y, Town or Lo	cation				10	d. Inside City Limi						
Director	Maryland	Word	ester			Pocomoke	City				1 ☐ Yes 2X N						
Dire						10f. Zip Code			10g.	Citizen of What Count	•						
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by Funeral	1 Never Ma	arried 2□ Marrie 1 4 □Divorced	Armed Forces	:?	rld	Yes, specify Cuba	dispanic Origin? (S an, Mexican, Puer Specify:	o Rican, etc.)	5	Black, White, e							
ted	/0-	15. Decedent's	Education	war .	1	ent's Usual Occup	nation during most of wor	4.*	16b	o. Kind of Business/Ind							
Completed	Elementary/Se	ecify only highest condary (0-12)	Grade completed) College (1-4o	r 5+)	life. [NOT use retired	during most of wor d)	king									
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Be		e (First, Middle, La	ast)				18. Mother's Nan			den Sumame)							
P		McGrath Name/Relationshi	n (Tivon Print)		10h Mailie	a Address (Otront	Addie Ma			ity or Town, State, Zip	0-4-1						
			Nephew, Perso	nal Do		,											
	20a. Method of D		repress relac	20b. F	lace of Dispos	sition (Name of		Date		. Location - City or Tov							
		2 Cremation 3	B Removal from State	9	-	natory or other plac	1	20 2007									
	Land to the second seco	Funeral Service Li	1500 Bill	ull	22	Name and Address Bradshaw	ss of Facility & Sons I	Funeral	Но	isfield, Ma							
	Mary Beth Bradshaw-Pruitt 306 W. Main St Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between																
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	resulting in death		a. Due to (or a	s conseq	uence of):	_	~ 4-1			7	ou-						
١.	Sequentially list conditions b. High As A Company (Conditions)								au								
ine	Sequentially list of any, leading to cause. Enter Unicause (Disease)	immediate denying	Due o (or as soursequence of):														
Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):								-								
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by Physician/M		12 months? 2 ☑No	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	Ideath 3 🗌	Ectopic pregnancy Other (specify)	1			23d. Date of deliver Month	y Day Year						
v Ph	Part II. Other sign	nificant condition	s contributing to death	but not res	ulting in the un	derlying cause give	en in Part I.	23e. Did	tobaco	co use contribute to the	cause of death?						
-							1 Yes 2 10 3 Probably 4 Unknow										
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ompieted									-								
e Completed	25. Was case ref	erred to medical	N. C.				26. Place of Dea	th (Check only	JIII J	examiner? 1 Yes 2 Wo Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Jurising Home 5 Residence 6 Other (Specify)							
Completed	25. Was case reference examiner?	J.NO	i inpar		ER/Outpatient	3 DUA	er: 4 ursing H			e 6 ☐Other (Specify)							
To Be Completed	25. Was case refrexaminer? 1 Yes 2 27. Manner of De. 1 Natural 2 Accident	ath 5 Pending investiga	28a. Date of In (Month, D		ER/Outpatient 28b. Time of Injury	28c. Injun	er: 4 ursing H		dence								
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ORIGINAL

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ř	Physic		TODI II FINDDENTON DOM									
	/Medical Examiner		4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL		4b. City, Town, or Locatio		4c. County of Dea					
	Funeral Director		5. Social Security Number 6. Sex 7. As 1 M 2 F	ge (In yrs. last birthday) 61 Yrs.	if Under 1 Year If Und Months Days Hours	ler 24 Hrs. 8. Date of Bi s Min. (Month, D JULY	ay, Year) Co	thplace (State or Foreign ountry)				
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits				
	with the Marylanda or 28a-f show	tor	MD ALLEGANY	CUMBERLAN	ID			1¥∑Yes 2 No				
	ith the or 28a e noti	Director	10e. Street and Number		10f. Zip Code		10g. Citizeп of What Co	ountry?				
	s 23a	ral [456 COLUMBIA STREET		21502		USA					
36	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show dical Examiner must be notified at	by Funeral I	11. Marital Status 1 □ Never Married 2 Married 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? 1 □ Yes 2 Married If Yes, Give Year or Dates:	No I	Was Decedent of Hispanic (If Yes, specify Cuban, Mexic 1 ☐ Yes 2⁄x No <i>Speci</i> f		0 "					
Maryland 21215-0036	72 hou natura ilcal E	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Decec	16a. Decedent's Usual Occupation		16b. Kind of Business/					
121	d within 72 ho giene. Ir than "natu the Medical	Completed	Elementary/Secondary (0-12) College (1-4or s	0+)	kind of work done during mo DO NOT use retired)		NURSING HO	ME				
d 2	it the E	Be Co	17. Father's Name (First, Middle, Last)	URDE	RLY AND MAIN	L'ENANCE MAN ther's Name (First, Middle		ME.				
/lan	should be and Mental s marked o umatic eve	To B	CHARLES A. BOBO			N E. (TIMBRO						
Jan	2 sho and I Is ma rauma		19a. Informant's Name/Relationship (Type. Print)		g Address (Street and Num			Zip Code)				
Baltimore, N	Pages 1 and 2 should nent of Health and Mer nt: If Item 27 Is marke iry or other traumatic		CINDY LOU BOBO WIFE 20a. Method of Disposition		COLUMBIA ST.	, CUMBERLAND), MD 21502 20c. Location - City or	Town Ptate				
			1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		sition (Name of natory or other place) MEMORIAL PARE		·					
Balti	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee	22	Name and Address of Faction NATIONAL	HAFER FUN	ERAL SERVIC	E, PA				
			23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final									
	Physician /Medical	discase of condition										
68760, B	ificate be executed physician and as the burial-transit	hysician/Medical Examiner	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		onary Ar	RIGRY DI	<i>32A</i> 32	IVR.			
P.O. Box 68	requires that the death certifica een signed by the attending ph hould be detached for use as th			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	23d. Date of deli Month	very Day Year				
	quires that n signed b ıld be deta	by	Part II. Other significant conditions contributing to death b	ut not resulting in the un	derlying cause given in Part		tobacco use contribute to	the cause of death?				
or Vital Records,	The law ate has b	Completed	25. Was case referred to medical				psy prior to death? 2 No 1 □ Yes	topsy findings available ompletion of cause of 2 No				
>	ysicla is cert direct	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatie	ent 2 TER/Outpatient	Othor	ce of Death (Check only o		364				
o uoi	To the Hospital or Attending Physician: whith 24 hours after death. To the Funeral Director After this certifica completely filled in by the funeral director,		27. Manner of Death 1 Natural 5 Pending (Month, Day 2 Accident investigation	ry 28b. Time of	28c. Injury at Work? M 1 Yes 2	28d. Describe	me 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred					
UIVISION	s after desal our Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injubiliding, etc	ury - At home, farm, stre c. (Specify)								
	To the Hospital or A within 24 hours after To the Funeral Tree completely filled in by	edical (29a. Certifier (Check only one) Certifying Physician: To the best of and manner start.	l examination and/or inv	occurred at the time, date a restigation, in my opinion, de	and place, and due to the eath occurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)				
	To th within To th compl	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Month	ı, Day, Year)				
)			Marine		D33280		April 5, 20	07				
	6		30. Name and address of person who completed cause of de GUPTA, SUNIL K., M.D., 625		,	, CUMBERLAND	, MD 21502					
	Sta Registr	-		ar's Signature	rate)							

Marcus Bernard Brown

2007			3	2	-
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	F	- For State equistrar		icate of Death	a Wichtai	Re	g No.	1 1132
Physicia Jedical Examin		Decedent's Name (First, Middle,Last) MARCUS BERNARD)	BROWN		2. Date of Deat Month March 22,		3. Time of Death 2231 hrs
		la. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of De		4c. County of Deat	
Funeral	4	Prince George's Hospital Center 5. Social Security Number 6. Sex 7. Age (In y	rs. last t	Cheverly oirthday) If Under 1 Yea	r If Under 24	Hrs. 8. Date of 8irt	Prince Georg	
Director	L	217-29-8938 _{1XM 2F} 16		Yrs. Months Day		AUG. 4	Forei	gn MARYLAND
any	-	Usual Residence of Decedent 10a. State 10b. County 10c. (City, Tov	wn or Location				10d. Inside City Limits
vlaryland 28a-f show any dat once.	١	MD PRINCE GEORGE'S	HYA	ATTSVILLE				1 X Yes 2 No
th the Maryland 23a or 28a-f sho	Director	10e. Street and Number 5461 MADISON WAY # 6		10f. Zip Code	0784	10	U.S.A.	ntry?
leath with items 23	Funeral	1. Marital Status 1. XNever Married 2 Married Armed Forces? 1. Yes 2 X N		13. Was Decedent of His If Yes, specify Cubar			14. Race - Ame White, etc.	ican Indian, 8lack,
irs after d ural", or	ᇍ	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completer.		1 Yes 2 No		of work done	Specify: BLA	
5-0036 lited within 72 hours after death with the Maryland Hygiene. 5 other than "natural", or items 23a or 28a-f shith Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 9th		during most of working life STUDENT	. DO NOT use	retired)	NONE	
21215-0036 Suld be filed within 7 Mental Hygiene. Marked other than c event, the Medica	Be Con	17. Father's Name (First, Middle, Last) JAMES A. GREER				eme (First, Middle, N HA BROWN	faiden Surname)	
MD 21215 nd 2 should be file lith and Mental H m 27 is marked o		9a. Informant's Name/Relationship (Type, Print) JAMES GREER/FATHER	1	19b. Mailing Address (Stree 5012 CHESTER				
0. # 2 = ±	ľ	20a. Method of Disposition 1 8urial 2 X Cremation 3 Removal from State	crem	ee of Disposition (Name of central place)		Date	20c. Location - City o	
Baltimore, permit Pages I at Department of He Important! If ite injury or other tr	ŀ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	RIVE	ERDALE CREMATO 22. Name and Address	s of Facility		RIVERDALE KINS FUNERA	AL HOME
យ ឧភ ±.៩ Physician	\dashv	23a. Part I. Enter the disease, or complications that caused the di	eath. Do				VER s MARYLA	ND 20785 Approximate Interval
rifysician √Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Asthma						Between Onset and Death
No		or condition resulting in death) Due to (or as a consequen Sequentially list conditions, b.	.ce ot):					
	Examiner	if any, leading to immediate Due to (or as a consequen cause. Enter Underlying Cause Disease or injury that initiated	ice of):					
uted nd transit	Exar	events resulting in death) Last Due to (or as a consequen	ice ot):					
0, : be exessician a	edica	X UNPENDED AMENDED #23a,PII,27,p F FEMALE: 23c. If yes, outcome of particular to the control of the control	erME.	, g866, 4/11/07 T	Π			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/M	F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown 9 Unknown		2 Fetal death 3	Ectopic pre	gnancy	23d. Date of delive Month	ry Day Year
that the de need by the detached for		Part II. Other significant conditions contributing to death but r	not resul	Iting in the underlying cause	given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
P. C. iries that	d by	Cardiomegaly				1 Yes		bably 4 ✓ Unknown /,
cords, law requir	Completed		_			24a. Was autop	sy prior to	utopsy findings available completion of cause of
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical		26 Place	e of Death (Che	1 V Yes	2 No 1 V	es 2 No
Vital hysician this cen	Ö	examiner?	2 🗸 ER	R/Outpatient 3 DOA	O45		Residence 6 Other	er:
n of viding Physics After the funeral	on: T	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	28		ıry at Work? Yes 2 No	28d. Describe l	now injury occurred	
Division pital or Attend ours after death teral Directors	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury -	At home	e, farm, street, factory, office	building, etc.	28f. Location (\$ or Town, S		ural Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowne) 2 W Medical Examiner: On the basis of examination	wledge,	death occurred at the time, d	late and place,	and due to the caused at the time date	e(s) and manner as sta	ted.
To the within To the comple	Medical	2 Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier	ion and/0	29c. Licens		os at the time, date	29d. Date signed (M	
		Caral Hal	Qa	(m) 0.C.	M.E.	. <u> </u>	March 23, 2007	
Q		30. Name and address of person who completed cause of death Carol Allan, MD Assistant Medical Examine	er 11	11 Penn Street, Baltim	nore, MD 21	201		
Sta	ate	31. Date filed (Month, Day Year) 32. Registrar's Sig	gnatur	9 16 1				

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760,

Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** JOAN BURNS IOLET MARCH 25 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RAMPALLSTOWN HOSPITAL CENTER BALTIMORE NORTHWEST If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 178-05-6096 92 yrs. Hours 1 □ M 2 🚾 F Sept. 27, **Director** Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner with the Conference of the conferenc 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10808 Drumm Avenue 20895 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify:White Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ William Bielski Mary Drill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole L. Haas/ Daughter 1915 Hillcrest Road, Baltimore, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐xBurial 2 ☐ Cremation 3 ☐ Removal from State March 29, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. - Ken SKils 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBROYASCULAR ACUTE Due to (or as a consequence of): Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed Were autopsy findings available prior to completion of cause of certificate has autopsy perform death? 1 □ Yes 2 □ No 1☐ Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 2 Accident (Month, Day Year) 5 Pending Injury To the Hospitai or Attendi within 24 hours after death. To the Funerai Director: A 1 ☐ Yes 2 ☐ No investigation by the f 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar 31. Date filed (Month, Day, Year) MAR 27 200

ERAHALLI

(Check only one)

29b. Signature and title of certifier



and manner stated

HYSICIAN

Name and address of person who completed cause of death (Item 23a) (Type, Print)

License number .

NORTHWEST

5401

29d. Date signed (Month, Day, Year)

HOSPITAL

2007

CEMTER.

			For State Registrar	State of N	Maryland		artment of rtificate o				giene Reg. No. 2 (107	1132
k	Physici	an	Decedent's Name (First, Middle,	Last)						2. Date of De Month	Day	Year	3. Time of Death
	/Medic	cal	Louise W. Brown 4a. Facility Name (If not institution,	give street and number	ur)		4b. City, Towr	n. or Location		iarch 2	4c. County		11:05pm ^M
	Examin	ier	Brighton Garden			ne	North E	_	_			gomer	У
	Funeral				Age (In yrs. las		If Under 1 Ye Months Day		Min.	B. Date of Bir (Month, Da	y, Year)	Count	* /
'n	Director		246-12-2271 Usual Residence of Decedent		88	115.				Aug. 28	3, 1918	West	Virginia
	yland how at		10a. State 10b. County		10c. City, *	Town or Lo	ocation					10	od. Inside City Limits
	ne Mar 8a-f s	Director	Maryland Montgo	mery	Kens	ingt					40 000	1	1 □Yes 2 No
	with the a or 2	Dir	10e. Street and Number 4416 Puller Driv	•			10f. Zip Cod				10g. Citizen of		
	ms 23	Funeral	11. Marital Status	12. Was Deceder		13.	Was Decedent of		Origin? (Spec	ify Yes or No	United 14. Rac	ce - America	an Indian,
٥	after or itel		1 Never Married 2 Marrie	If Yes, Give	₹ No		in Yes, specify C 1 ☐ Yes 2 🕱 N			ican, etc.)	Specif	ck, White, e	
3-00-c	ified within 72 hours after death with the Maryland II Hygiene. other than "natural", or items 23a or 28a-f show rent, the Medical Examiner must be notified at	ed by	3X Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates		16a Dece	dent's Usual Oc	cupation			16b. Kind of B	W	hite
<u>.</u>	nin 72 In "nat Medica	plete	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-40		(Give life.	kind of work do DO NOT use ret	ne during m ired)	ost of working	g		40110001110	4 5 <i>y</i>
7	ed with /giene er tha t, the I	Completed		5+		Mus	ic Teach				Music E		ion
yland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	Be	17. Father's Name (First, Middle, L.	•							, Maiden Surnar	me)	
	2 should be and Mental ris marked or raumatic ever	မှ	Richard Breason 19a. Informant's Name/Relationshi			19b. Maili	ng Address (Stre		Feams		er, City or Town,	, State, Zip	Code)
_	1 and 2 s Health ar tem 27 is		Teresa Wallendja		ter)	4416	Puller	Drive	, Kens	ingtor	n, MD 20	895	
ore,	es 1 a of He if item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation	B □ Removal from Sta	20b. Plac	ce of Disponetery, cre	osition (Name of matory or other)	olace)	Da	ite	20c. Location	- City or Tov	wn, State
Dallinor	t. Pag tment tant: I		4 □ Donation 5 □ Other (Spe	ecify)			itan Cre						Virginia
0	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Li	Della 1		10 G	2. Name and Ad) East I aithersh	dress of Fac Deer P Durg,	ark Dr MD 208	ive 95	eral Hom	ie	
	4		23a. Part1. Enter the disease, or c	omplications that caus	sed the death.						rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_	tion Pn		nia						Offset and Death
	/Medical Examiner		resulting in death)		as a conseque	nce of):							
	Sec. (8)	Jer	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b. Dement:	as a conseque	nce of):							
	ecuted nd transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last				eart Dis	ease					
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Š	th cert ending r use a	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon 1 ☐ Live birth	ne pf pregnand 1 2 🗆 Fetal d		∃Ectopic pregna	ıncv				ate of deliver	
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	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u		(Check only 2 Medical E	Physician: To the be xaminer: On the basis	of examinatio								
	o the lithin 2 o the o the o	Medical	29b. Signature and title of certifier	and manner	stated.		29c. Lice	ense numbe	er		29d. Date signe	ed (Month, E	Day, Year)
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	U		30. Name and address of person w								Harch	, _	<u> </u>
			Dr. Ajay Reddy,				Lvd., Be	ethesd	la, MD	20817			
	Sta Registr			2007	strar's Signatui		ask)						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Month Year **Physician** March 23, 4:00pm M Scott Matthew Bowns /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 20504 Cross Jack Place Montgomery Village Montgomery 8. Date of Birth (Month, Day, Year)
April 26, 1963

9. Birthplace (State G.), Country)
Connecticut If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 110 M 2 T F Director 43 215-90-1176 Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Montgomery Montgomery Village 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20504 Cross Jack Place 20886 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Salesman Computer Software other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Health and Mental should be Carole Martha Spengeman George Arthur Bowns 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20504 Cross Jack Place, Montgomery Village, MD 20886 Jennifer Bowns (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages Department of I Important: If It any Injury or o ō 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Alexandria, Virginia Metropolitan Crematory 3/24/07 eral Service 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20077 21. Signature of Eu 2.4. Part1. Epler the dise standard or respiratory arrest, shock or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Brain Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter United Injury Due to (or as a consequence of): The law requires that the death certificate be executed physicien and s the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month ō Day 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 X No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 🙀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After Injury 1 ☑Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0064615 March 24, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1335 Piccard Drive, Rockville, MD 20852 Genevieve Wroblewski, M.D., 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 2 7 Dall ser Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Edythe P. Blackman March 2007 9:05 P /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 7004 Wilson Lane Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F 052-03-0178 Director 91 July 16, 1915 New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits MD Montgomery 1XXYes 2 □ No Director Bethesda 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? "natural", or items 23a or dicat Examiner must be r 7004 Wilson Lane 20817 United States Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Dental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 is marked o Julius Penzner Anna Saizow P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Meredith L. Elrod/ Daughter 11305 Commonwealth Drive Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 10 = 10 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page:
Department or
Important: If i 03-27-2007 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) National Crematory Joseph Gawler's Sons Inc. 21. Signature of Funerah Service Licenses 5130 Wisconsin Ave. NW Washington, DC 20016 LIMAL 23a. Part1. Enter the disease or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in leach line. Immediate Cause (Final Physician End Stage Renal Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undership Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 💢 No the detached 9□Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1☐ Yes 2CXNo Be (25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

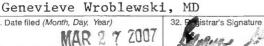
> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MAR 2

30. Name and address of person who completed cause of death (item 23a) (Type, Print)



MD

m

29c. License number

D0064615

29d. Date signed (Month, Day, Year)

03-26-2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 24, Day **Physician** 2007° ar 2:55A. M Helen E. Bell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours March21,1921 1 □ M 2 ▼F West Virginia 233-26-7303 86 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Items 23a or 28a-f show event, the Medical Examiner must be notified at Maryland Montgomery Silver Spring 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3126 Gracefield Road, #320 20904 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 📉 No White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ns any Injury or other traumatic event; the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert A. Smith Ada Lula Cochran 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3126 Gracefield Road,#320 Silver Spring, Md. 20904 Clarence E. Bell -husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State t Burial 2 □ Cremation 3 □ Removal from State 3/28/2007 Union Cemetery Burtonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, PA Maryland 20705 Honald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiac tamponade /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 XNo 3 Probably 4 □Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

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MAR 2 7 32 Registrar's Signature State

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DHMH 17 Rev 1/2001

/Medical Examiner attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760, After

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Director

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Pages 1 and 2 ment of Health a ant: if item 27 is ury or other trains

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Physician

altimore, Maryland 21215-0036

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DHMH 17 Rev 1/2001

State

Registrar

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CALUGRT MENDRIAL HOSPITAL , SUITE 310, PRINCE PREDERICE NOD-20678.

03/23/07

3411103M

2007 Signature

W.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DALVIE AMBBERN

MAR 2 7

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 3 Eleanor Kathleen Baker 0045 0 /Medical 25 0) 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Teniventa Kegional If Under 1 Year | Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 🔀 F Yrs. 220-10-9969 Director 85 11-19-1921 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show iral", or Items 23a or 28a-f sh Examiner must be notified 1 Tyes 2X No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 126 W. Fairfield Drive Funeral 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 X Married \mathcal{L}_{coll} \mathcal{L}_{conn} \mathcal{L}_{coll} Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Completed by Specify Specify: 3 Widowed 4 Divorced White "natural" of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Beautician Cosmetology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be flik tment of Health and Mental Hi tant: If Item 27 is marked oth Be 2 Robert Samuel Windsor Dorothy Belle Workman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Calvin J. Baker Fairfiled Dr., Salisbury, Maryland 21804 126 W. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of I-Important: If Ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parsons Cemetery 3-28-07 Saslibury, Maryland 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service, 705 E. Main Street, Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** myocarde disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner atheroscheotic CONOMICY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) been signed by the s 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 NO 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown has r 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an After this certificate has funeral director, page 2: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2P No Inpatient P 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 80t 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Silvia nus Regional 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 27

2007

12:14am

Birthplace (State or Foreign Country)

White

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

1 ☐ Yes 2 No

State Registrar

DHMH 17 Rev 1/2001

5530 Wisconsin Ave. #1208, Chevy Chase MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Jeffrey P. Muench MD.

MAR 27

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 25, 2007 12:20A M Joseph E. Callaway March /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Delmar 8428 Rum Ridge Road If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 10XM 2□ F 93 218-05-8986 Delaware Director 1, 1914 Usuel Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral', or iteme 23a or 28a-f show Examiner must be notified at 1 Tyes 2X No Director Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8428 Rum Ridge Road 21875 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 225 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white þ 3 XWidowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chickens/Grains/Plants Farmer other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked o Hester Truitt Grover Callaway 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Darlene C. Alexander 8428 Rum Ridge Road Delmar, MD 21875 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3-28-2007 Injury or Salisbury, Maryland ¹ 4 □ Donation 5 □ Other (Specify) Wicomico Memorial Park 22. Name and Address of Facility
Short Funeral Home permit. 21. Signature of Funeral Service Licensee Delmar, DE 19940 w 13 E. Grove Street 23a. Part 1. Effer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DMao **Physician** /Medical Due to (or as e consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physicien and I for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown signed by d be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 1 No 3 Probably 4 Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 2 No 1 Yes Be 25. Was case referred to medical examiner? / 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient dir ၉ 1 Yes 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral C 1🖆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) faue an 100 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State	State of Maryla				Mental Hygie	ne nn 7	11336
			Registrar		Cen	tificate d	of Death	Reg.	No.	11000
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give	idrew D	errice	KSON Ab City Tow	n, or Location of Dea		Day Year A4, 2007 4c. County of Death	
	Examir	ner			ADMIDD				WICO	
	Funeral Director		211-30-1609	& NURSING 7. Age (In yr 7 5 6	s. last birthday) Yrs.	If Under 1 Ye Months Da		8. Date of Birth	9. Birth	place (State or Foreign intry)
30	and w		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Loc	ation				10d. Inside City Limits
KS	the Marylar 28a-f show	ector	Md. Worces	ster B	erlin	10f. Zip Cod		100	Citizen of What Cou	1 ☐ Yes 20 No
7	들 하 및	Funeral Director	9639 Seghawk	Road 12. Was Decedent Ever in	U.S. 13 W	21	811 of Hispanic Origin? (5		14. Race - America	1,
) er	n 72 hours after death w "natural", or Itams 23a blical Exercine must b	Ď	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 A Yes 2 □ No 1 Q If Yes, Give Year or Dates: 1	69 11	Yes, specify C	Cuban, Mexican, Puer	to Rican, etc.)	Black, White,	
215-0	within 72 ho ene. then "natur	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Decede (Give k	ent's Usual Oc ind of work do O NOT use re	ccupation one during most of wo tired)	rking 0	o. Kind of Business/In	idustry Bros.
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/es	Mental Merked o	To Be	17. Father's Name (First, Middle, Last) Andrew Char	-lc Derr	Kson	Sr.	Marc	me (First, Middle, Mail	25	
Z a	2 short and lam		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailing	Address (Str	eet and Number or F	ura, Route Number, Ci	ity or Town, State, Zip	o Code)
re, r	es 1 and 2 of Health fitam 27 I		20a. Method of Disposition		Place of Disposi	ition (Name of	awk K	Date 200	c. Location - City or To	own, State
altimore	nit. Pages lartment of l ortant: If it injury or o		1 1 Burial 2 □ Cremation 3 □ R `4 □ Donation 5 □ Other (Specify)	emoval from State	L P Coul	Cena	+= 13-3	1-00 Bo	colin N	1d.
Balt	permit. Page Department o Important: If any injury or once.	İ	21. Sign ture of Funeral Service License	Rainels	22. P	Name and Ad	Idress Facility Bo	comic Smills	th Funci	ral Hone 21851
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	cations that caused the de	ath. Do not enter	the mode of	dying, such as cardia		119/1-41	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a const	quenge of):	7		9	,	elan
	Examiner	er	Sequentially list conditions, if any, leading to immediate	Due to pr as a conse	squence of	Han	-07-160	y.		424-
	uted insit	Examine	Cause (Disease or injury	4	A CONTRACTOR OF THE CONTRACTOR	7				. 011
ć	be executed sician and burial-transit	Еха	that initiated events cresulting in death) Last	Due to a conse	quence of):	-/4/			7	IN -
8760,	icate be physicia s the bur	cal	C a	. Ou	tele					PART
P.O. Box 68	ne death certif the attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3 □E	Ectopic pregna Other <i>(specify)</i>			23d. Date of delive Month	ery Day Year
<u>s</u> .	res that the igned by be detact	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the und	lerlying cause	given in Part I.		co use contribute to the	
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Division of Vital Records,	lcian: The law certificate has I ector, page 2 s	Completed						24a. Was an autopsy performed	prior to condeath?	opsy findings available impletion of cause of
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o	g Phys er this eral dii	. To	1 Yes 2 No	28a. Date of Injury (Month, Day Year)	28b. Time of	3 DOA	4 Mursing F	lome 5 Residence		у)
on	th. : After	atlor	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. ln V M 1	Vork? □Yes 2□No		,,	
Divisi	To the Hospital or Attendi within 24 hours after death. To tha Funaral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	nome, farm, stree	et, factory, office	ce	28f. Location (Street City or Town, St	t and Number or Rura late)	Il Route Number,
	e Hospital	edical (29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my kner: On the basis of examinand manner stated.	owledge, death o ation and/or inve	occurred at the stigation, in m	e time, date and place by opinion, death occu	, and due to the cause irred at the time, date	e(s) and manner as st and place, and due to	tated. o the cause(s)
	To the within 2 To tha comple	Me	29b. Signature and title of certifier	0		29c. Lice	ense number	29d.	Date signed (Month,	Day, Year)
			1000	1		0	2834	9 2	126/07	
RD	2+1		30. Name and address of person who con WILLIAM ROBINS,				BURY, MD	21804	7 1	
UM .	Sta	le.	31. Date filed (Month, Day, Year)	20 24-11-1-01-			DOKT / PID •	51004		
	Registra		MAR 2 7 200	32. Higgistrans Sign	J. Go	de				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vear Physician Month 2049 PM Raymond Frederick Day MARCH 1007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Co. Hospital Washington Hagerstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | November 32.5 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** New Jersey 150-26-4185 73 Director Usual Residence of Decedent sa or 28a-f show t be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Pennsylvania Franklin Greencastle XXIYes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 19225 4095 Coseytown Road USA 23a Examiner must Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 0 1 ☐ Yes XX No Specify: Specify: ģ 3 Widowed 4 Divorced Wshite 'natural", Completed d other than "natur event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Men US Military US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond E. Day Phyillis Ione Pilbro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4095 Coseytown Road, Greencastle, PA 19a. Informant's Name/Relationship (Type. Print) Gladys Day (Wife) 20a. Method of Disposition 1 ☐ Burial 2 Ocremation 3 Enemoval from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Crematory Unknown Harrisburg, PA 4 Donation 5 Other (Specify) 21. Si nature of Juneral Samue Licensee Chistampfor M-0084 Locastamoror Funeral Home, Inc. 48 S. Church Street, Waynesboro, PA 17268 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause of each Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due (or as a consequence of): Examiner Esqueritally liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) 1□Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ₩0 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical ■ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and francer stated. (Check only one)

the death certificate be executed and burial-Box 68760. attending physician for use as the buria Ö signed by t Records, peen cate has t certificate Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p

filed within 72 hours after death with the

Maryland 21215-0036

Baltimore,

OH 2+1

State Registrar

Date filed (Month, Day, Year) APR 05 2007

29b. Signature and title of certifier

415 11° 32. Registrar's Signature

nd address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

29c. License number

10

29b. Signature and title of certifier

Brian Carpenter,

MAR 2 7

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

M.D.

Registrar DHMH 17 Rev 1/2001

State

29c, License number

DOUG4502

9901 Medical Center Drive, Rockville, Maryland 20850

29d, Date signed (Month, Day, Year)

			For 1 _ State	State of Maryla	-			Mental Hy	giene				
		-											
	Physicia							Month	Day Ye	ar 10:00 A M			
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of Death		4c. County of D				
,			955 Hillside Lake	Terrace #95	5	Gaither	sburg		Montgo	mery			
П	Funeral		Social Security Number 6. Sex	7. Age (In yi	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th 9.	Birthplace (State or Foreign Country)			
	Director		1/5-24-1866	76	Yrs.			Aug. 9	9, 1930	PA			
	and w t		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	ocation				10d. Inside City Limits			
	Maryl f sho	tor	Maryland Montgome		Codeb	ah				1 X Yes 2 □ No			
	r 28a	Directo	10e. Street and Number	- У	Gaith	ersburg 10f. Zip Code			10g. Citizen of What	Country?			
	th with		955 Hillside Lake	Terrace #955	i	2087	8		U.S.	Δ.			
	ems :	Funeral		12. Was Decedent Ever in Armed Forces?			lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No		American Indian, Vhite, etc.			
õ	afte or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 🗓 No	Specify:	,	Specify:	White			
-00030	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notifled at		3 ☐ Widowed 4 🏋 Divorced 15. Decedent's Educ	Year or Dates:	16a Dece	dent's Usual Occup	nation		16b. Kind of Busine	aco/Industry			
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-	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle	, Maiden Surname)				
yland	uld bu Mente irked	ToE	Samuel Manganell	.0			Marie	Mariar	10				
Mar	2 sho and is ma		19a. Informant's Name/Relationship (Type						er, City or Town, Sta	te, Zip Code)			
e, e	l and lealth im 27 ther tu		Carmen Withers / S			sition (Name of		Date Date	20c. Location - City	T			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one.		20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ R	emoval from State Me	cemetery, cre	mátory or other pla: Ltan	ce) ¦	h_24,	·	·			
baltimor	iit. Pa urtmei ortant njury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		Cremato	ory	20	007	Alexandr neral Home	ia, Virginia			
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			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the de						Approximate			
	Physician		Immediate Cause (Final disease or condition			Dissect				Interval Between Onset and Death 7 Years			
l.	/Medical		resulting in death)	Due to (or as a cons						, 10010			
	Examiner		Sequentially list conditions.										
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	and I-tran	xan	that initiated events resulting in death) Last	 Due to (or as a cons	equence of):								
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X D D	h cert	Z	230. Was decedent pregnant	3c. if yes, outcome pf preg 1 □ Live birth 2 □ Fe		∃Ectopic pregnanc			23d. Date of	delivery			
_	e deat	sicia	in the past 12 months? 1 ☐ Yes 2 💢 No	4☐Pregnant at time o		Other (specify)	у		Month	Day Year			
г Э	w requires that the death certific been signed by the attending p should be detached for use as	Physician/M	9 Unknown					00- 014					
ń	ires the signed	by	Part II. Other significant conditions cor Status Post Aortic		•	nderlying cause giv	en in Part I.	23e. Did t		e to the cause of death? Probably 4 Unknown			
ecords,	requ bould	Completed	Status Fost Auftit	vaive kepia	icement					Trobably 4 Dorkhown			
5	has the 2 s	mpl						24a. Was auto	psv prior	e autopsy findings available to completion of cause of h?			
ונס אונס	n: Th ficate or, pag	ဝင္ပ	25. Was case referred to medical				00 Ph (P		2 X No 1 1	Yes 2 No			
	rsicia s certi lirecto	00	examiner?	lospital: 1 ☐ Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth	26. Place of Deat		one) dence 6 □Other (5	Sana Mil			
5	g Phy er this eral c	n: To	27. Manner of Death	28a. Date of injury	28b. Time o				how injury occurred	specify)			
5	ath. or: Aft	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		Yes 2 □No						
UNISION	ir Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At building, etc. (Spe	home, farm, sti	reet, factory, office		28f. Location (Street and Number o wn, State)	r Rural Route Number,			
ב	ital o												
	Hosp 24 hou Fune stely fi	edical	29a. Certifier (Check only one) 1	sician: To the best of my kiner: On the basis of exami	mowledge, deat ination and/or in	h occurred at the ti vestigation, in my	me, date and place, opinion, death occur	, and due to the rred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Med	29b. Signature and title of Gertifier	and manner stated.	7 -	29c. Licens	se nu m ber		29d. Date signed (M	onth, Day, Year)			
	p ≤ p Ö		· alle	12 50	M	מ	07147		3/21/0				
,	b		30. Name and address of person who co	mpleted cause of death (It	em 23a) (Type,				-,,0	1			
			Allen Nimetz, M.D.				nevy Chase	e, Mary	1and 20815	i			
31	Sta		31. Date filed (Month, Day, Year)		nature								
	Registr	ar	MAR 2 7 200	De Alter	A. A.	The same							

			1 - For State Registrar	State of Maryla	•	artment of H		-	giene Reg. No.	7 11340
			Decedent's Name (First, Middle, La	2. Date of Da	ath	3. Time of Death				
	Physic /Medi		JESSE RAYM	OND GAR	RISON	.TR -		March	26, 2007	7:15 P M
	Exami		4a. Facility Name (If not institution, given		III DON	4b. City, Town, or	Location of Dea		4c. County of E	
			4451 Box Iron Ro	ad		Cri	sfield		Some	erset
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birt	th O	Birthplace (State or Foreign
	Director		222-20-8347	IMM ZUF	74 Yrs.			Jan 2	9, 1933 M	aryland
	and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Manyl f sho	ō	Manual Camana		•	<i>Q</i> -	.: : 1 . 3			1 ☐ Yes 2 X No
	ith the Marylar or 28a-f show	rect	Maryland Somers 10e. Street and Number	set		10f. Zip Code	risfield		10g. Citizen of What	Country?
	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show actural', or Itams 23a or 28a-f show actural to a confined at	Funeral Director	4451 Por Trop Dog	a		2181	17			•
	death ms 2	Jera	4451 Box Iron Roa	12. Was Decedent Ever in		Was Decedent of Hi	spanic Origin? (5	Specify Yes or No		JSA merican Indian,
9	after or Ita	Ξ	1 ☐ Never Married 2 ☒ Married	Armed Forces?	53-	If Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)	Black, V	Vhite, etc.
03	ral', c	1 by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 19	55	1 ☐ Yes 2X No	Specify:		Specify: \	MITCE
21215-0036	72 hours after dea "natural", or Itams	Completed by	15. Decedent's E (Specify only highest gro		16a. Dece	dent's Usual Occupa	ation during most of wo	nrkina	16b. Kind of Busine	ess/Industry
21	within ene. than "	du	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)	life.	DO NOT use retired)		G t	
2	filed within Hygiene. other than sent. It e Men		12 17. Father's Name (First, Middle, Last	1	Heavy	Equipmer			Constru	CETOU
and	ould be f Mental H larkad ot latic ever	Be	Jesse Raymond Gar					me (First, Middle, ia Mered	Maiden Sumame) ith	
Maryland	2 should be filed withir and Mental Hygiene. Is markad other then aumatic event. It e M.	2	19a. Informant's Name/Relationship		10h Mailie	an Address (Street a			er, City or Town, Stat	Zin Code)
Z		10	Mary Ruth Garriso						ld, MD 21	
ē,	ss 1 and 2 of Health Item 27 i		20a. Method of Disposition		. Place of Dispo			Date	20c. Location - City	
e E	Pages nent of I ant: If Its ary or o		1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special		,	30, 2007	Crisfield	, Maryland		
Baltimore,		l Y	21. Signature of Funeral Se			uneral H		,		
ä	Depar Depar Impor any in	1 1	Mary Beth Br	adshaw-Pruitt					ome 1d ,MD 21	817
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de						Approximate Interval Between
	Physician		tmmediate Cause (Final disease or condition		MYDO	ARDIAL	Thirle	CTIDAL		Onset and Death
	/Medical		resulting in death)	a Due to (or as a cons		ARVIAL	TINEWK	<u>C1 1010</u>		
	Examiner		Sequentially tist conditions.	b		ASC	VD			
	pe sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Einter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):					
	and and I-tran	хаш	that initiated events resulting in death) Last	c. Due to (or as a cons	aguagas of):					
8760,	cate be executed physician and the burial-transit	a E		Due to (or as a cons	equence on,					
587		dlcal		d						
Вох	ath ceriff tending or use as	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg	nancy				23d. Date of	delivery
m.	atile	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time or		Ectopic pregnancy Other (specify)			Month	Day Year
0	that the dead by the detached	hys	9 Unknown	9□ Unknown						
s, P	The law requires that the site has been signed by the sage 2 should be detached.	by P	Part II. Other significant conditions of	ontributing to death but not r	esulting in the ur	nderlying cause give	n in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
rd	en sig							1 🗆 Y	′es 2 □ No 3 □	Probably 4 Unknown
Record	e law requ has been je 2 should	Completed						24a. Was a	an 24b. Were	autopsy findings available to completion of cause of
Ä	n: The icate har r, page	Com						perfor	rmojed? death	
Vital	ician: certific rector,	Be (25. Was case referred to medical examiner?				26. Place of De	ath Check onl o	• 4	
of \	Physician: this certific ral director,	은	1 Xes 2 No		ER/Outpatien	t 3□ DOA Othe	4 Nursing H	lome 5 X Resid	dence 6 Other (S	(pecify)
	D e e	lon:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of tntury	28c. Injury Work	?	28d. Describe h	ow intury occurred	
isi	Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not b	9	hama farm str		es 2 □No	206 Lassian (C	N	2
Division	= 9 E	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	cify)	eet, factory, onice		City or Tow		Rural Route Number,
_	Hospital		29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of my k	nowledge, death	occurred at the time	e, date and place	and due to the o	Cause(s) and manner	as stated
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical	(Check only 2 Medical Exar	niner: On the basis of examinand manner stated.	nation and/or inv	estigation, in my op	inion, death occu	irred at the time, o	date and place, and o	due to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier	1 - 1	7-	29c. License	number	2	29d. Date signed (Me	onth, Day, Year)
•			• (\	VIT	7 1	D 480	098		March	28, 2007
			30. Name and address of person who							
+(Vijay Karumbur			Highway-	Crisfiel	d, MD 21	817	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig		_				
	riegisti	ai	MAR Z 8	2007 Kleen	15	South				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 4/3/2007 Anna C. Hansen 12:45 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Chevy Chase Manor Care Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 🗓 F 4/11/1917 102-22-3230 Canada Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🕅 No MID Montgomery Chevy Chase 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 3304 Rolling Road 20815 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: 3 Nidowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Health Care Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Cassidy James Brady 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Daughter 3304 Rolling Rd, Chevy Chase MD 20815 Ingrid Hansen 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖔 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/5/2007 | Smithsburg, MD Smithsburg Crem 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service License M01176 106 East Church St. Frederick, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, whock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Advan Dementio Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Unionying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nunknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No autopsy 1□ Yes 2 No 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural

Physician /Medical Examiner P.O. Box 68760.

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

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7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must

72 hours after

d 2 should be filed w th and Mental Hygier 7 is marked other th

mit. Pages 1 and 2 sl partment of Health an portant: If item 27 is 1 y Injury or other trau

Department of Important: If any injury or

Maryland 21215-0036

Baltimore,

Division or Vital Records,

Director

Funeral

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Completed

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Examiner burial-tran attending physician for use as the burial signed by the a d be detached for been signated the should the has certificate funeral director, this After t Hospital or Attendi 24 hours after death. Funeral Director: A etely filled in by the fr

Physician/Medical þ Completed Be မ Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated.

1 Yes 2 No

5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29b. Signature and title of certifier

10054566

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suridha Bhogaile 14702 Cherry heaf towar silversing MNZ0906 32 Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Medical



within 24 hours a To the Funeral D

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completely

State of Maryland / Department of Health and Mental Hygiene For Policy State Registra AMEND#10a, open FH3/27/07, BMW, Modo Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 5:30 P.M 2007 16, Margaret В. Hannan March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manor Care of Chevy Chase Montgomery Chevy Chase If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🕱 F Yrs 90 Director 26,1916 Washington, DC 579-26-5292 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TXYes 2 □ No Director D.C. Washington, DC 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20015 United States 5705 Chevy Chase Parkway, N.W. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify. þ 3 Widowed 4 Divorced White Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Washington, D.C. Elementary/Secondary (0-12) College (1-4or 5+) Elementary School Teacher Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Miller John Borger Mary ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 5705 Chevy Chase Parkway, N.W., Washington, DC 20015 Denis Hannan/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 3 Removal from State 1 X Burial 2 ☐ Cremation 3/21/2007 | Silver Spring, MD. 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cem. 22. Name and Address of Facility DeVol Funeral Home ture of Funeral Service Licen 10 East Deer Park Dr., Gaithersburg, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician PNEUMOR /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2☐No 3☐ Probably 4☐Unknown 1 Tes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy perform 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Pruneral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital Le Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 120107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13219 Executive Park Terrace, Germantown, MD. 20874 Truong Bao, M.D., 31. Date filed (Month, Day, Year)
MAR 2 7 2007 Registrar's Signature State Registrar

7 4 1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 19, Day 2007 Year Randall Troy Huffman 10:10 PM 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Year) Aug. 16, 1954 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 216-66-1094 1 X M 2 □ F 52 Maryland Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 1 □Yes 2\1\1No Maryland Montgomery North Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23 Dufief Court 20878 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 점 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 🖾 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) National Geographic College (1-4or 5+) Elementary/Secondary (0-12) Printer Society 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eli Huffman Opal Nadine Riggs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Annette Huffman (Wife) 23 Dufief Court, N. Potomac, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place)

Crematorium

Crematorium Date 20c. Location - City or Town, State 20a. Method of Disposition March 23, 2007 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, Maryland 20877 Approximate Interval Between Onset and Death 3 days 23a. Part 1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Immediat Cuse (Final disease or condition resulting in death) Septic Shock Due to (or as a consequence of): Pseudomonas Pneumonia 7 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Acute Pancreatitis weeks

Physician /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed

permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any injury or other trau
once.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

2 should be filed within 72 hours after death with to and Mental Hygiene.
Is marked other than "natural", or items 23a or 2

3altimore, Maryland 21215-0036

the Maryland

the burial-tran physician use as been signed by should be detach cate has page 2 s Within 24 hours after death To the Funeral Director:

Completed by

Be

Certification: To

Medical

29b. Signature

30. Name and a

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

the

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esulting in death) Last		Due to (or as a conseq	uence of):								
		Alcohol Dep	endence							yea	rs
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2	3c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 ⊟Ectopic					23d.	Date of de Month	livery Day	Year
art II. Other significant con-	ditions cor	ntributing to death but not resi	ulting in the underlying	cause g	iven in Part I.		23e. Did tobacco	use	contribute to	the caus	se of death?
Alcohol Withdrawal									lo 3∏P	robably	4 ⊠Unknown
Diabetes Muscular Dys	troph	y					24a. Was an autopsy performed?		prior to death?	utopsy fine completio	dings available n of cause of
25. Was case referred to med	dical				26. Place of Dea	ath (C		<u> </u>			
examiner? 1 Yes 2 No	F	lospital: 1 X Inpatient 2 □	ER/Outpatient 3 ☐ [OOA O	ther: 4 \(\text{Nursing F}	lome	5 ☐ Residence	6 🗆	Other (Spe	cify)	
Z LI Accident	estigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj W	ury at ork? ⊒ Yes 2 ⊒ No	28d.	Describe how inju	ury oc	ccurred		
3 Suicide 6 Could not b 4 Homicide determined		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number City or Town, State)							umber or R	ural Route	e Number,
		sician: To the best of my kno ner: On the basis of examina and manner stated.									ause(s)

29c. License number

D58681

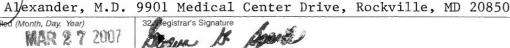
29d. Date signed (Month, Day, Year)

March 20, 2007

State Registrar

31. Date filed (Month, Day, Year) MAR 27

and title of certific



dress of person who completed cause of death (Item 23a) (Type, Print)

	1 - For State Registrar	State o	f Maryland	d / Dep		t of H	ealth a	and M	-		007		} 4 4
Dhysisian	1. Decedent's Name (First, Midd	lle, Last)		-	-				2. Date of Dea	ath Day	Yea	3. Time o	
Physician /Medical	William	Carroll	Harrup						March			7:00	рМ
Examiner	4a. Facility Name (If not institution	on, give street and nur	nber)		4b. City,	Town, or	Location	of Death		4c. 0	ounty of D	eath	
	2709 Woodedge				Silve	r Sr	ring			Mo	ntgor	nery	
Funeral	5. Social Security Number 579-05-7696	6. Sex 11 M 2 F	7. Age (In yrs. la		If Under Months	Days	If Under Hours	Min.	8. Date of Birt (Month, Da Jan 18	h y, Ye <i>ar</i>)	9. 6	Birthplace (State Country)	or Foreign
Director			87	Yrs.					Jan. 18	, 192	20 \	Virginia	
and w	Usual Residence of Decedent 10a. State 10b. Count	у	10c. City	, Town or Lo	ocation							10d. Inside C	ity Limits
f sho	Maryland Mon	tgomery		Silver	Snri	na						1 🗆 Yes	2 🔼 No
with the Mar s or 28a-f s: be natified Director	10e. Street and Number			DIIAGI	10f. Zip					10a. Citiz	en of What	Country?	
Mith With	2709 Woodedge	e Road				209	906			-	JSA	,	
1215-0036 within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show than "natural", or Items 23e or 28e-f show the Medical Examiner must be natified at ompleted by Funeral Director	11. Marital Status	12. Was Dece	edent Ever in U.S	S. 13.	Was Deced	ent of Hi	ispanic Ori	igin? (Spe	ecify Yes or No Rican, etc.)			merican Indian,	
riter Fun	1 ☐ Never Married 2 ☐ Ma		2 No						Rican, etc.)		Black, W	/hite, etc.	
030 urs a by	3 Widowed 4 Divorce	d If Yes, Giv Year or D		WII	1 ☐ Yes	2K_MNo	Specify:				Specify: V	White	
21215-0036 ed within 72 hours all yginen arriban "natural", or mer than "natural", or t. Ire Medical Exami	15. Decede	nt's Education est grade completed)		16a. Dece	dent's Usua kind of wor	il Occupa	ation	t of work	ina	16b. Kin	d of Busine	ss/Industry	
thin 7	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT us	e retired)	t OI WOIKI	nig .				
21 ad wi	12				river						pco		
be file tal Hydraule evani	17. Father's Name (First, Middle					1			(First, Middle,		Sumame)		
yla buld i Ment arke aric atic	Willie Harru	<u> </u>					Mat	tie	Dickers	on			
Maryland 21215-0036 d 2 should be filed within 72 hours after dea th and Mental Hygiene. 77 is marked other than "natural", or Itams traumatic event. The Medical Examiner mateum at the Medical Examiner mateum at the Be Completed by Funer	19a. Informant's Name/Relation	ship (Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	al Route Numbe	er, City or	Town, State	e, Zip Code)	
■ 5 = 7 1	_Frances D. Ha	rrup/Wife_	1	2709	Woode	đạe	Boad.	Si	lver Sp	ring,	MD 2	20306	
Or Or H ite	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from		lace of Dispo emetery, cre	osition (Nan matory or o	ne of ther plac	θ)		Date 76	20c. Loc	ation - City	or Town, State	
Pages ment of I ant: If its ury or o	' 4 ☐ Donation 5 ☐ Other (Gate	e of H	leaven	Cen	neter	y Mai	rch 26 2007	Silve	er Spr	ing, Ma:	ryland
Baltimore, permit. Pages 1 a Department of Hes Important: if item any injury or othe once.	21. Signature of Funeral Service	Licensee	00	F	rymer	d Addres	s of Facility	ins	Funera	1 Hon	ne Inc	·	
m gg = # 9	> Unde	w		100								ing, MD	20901
2200	23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that controls only on cause on e	aused the death	. Do not en	ter the mod-	e of dying	g, such as	cardiac o	or respiratory ar	rest,		Approxima Interval Be	tween
Physician	Immediate Cause (Final disease or condition	Huma	rtension	2								Onset and	
/Medical	resulting in death)		or as a consequ									Many Ye	ears_
Examiner	Conventially list conditions	b Coro	nary Art	terv D	iseas	е						Many Ye	ears
P = E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of Injury)		or as a consequ										
760, te be executed ysician and te burial-transit cal Examiner	that initiated events	с											
760, te be exerginal purial-	resulting in death) Last	Due to (or as a consequ	ience of):									
		d										-	
e as le	IF FEMALE:												
Box eath cert attendin for use.	23b. Was decedent pregnant in the past 12 months?		come of pregnar irth 2 ☐ Fetal		□Ectopic pr	egnancy				23	3d. Date of Month		Year
O. E de	1 ☐ Yes 2 ☐ No	4☐Pregn 9☐Unkno	ant at time of de	ath 5	Other (sp	ecify)					WORTH	Day	1 601
I Records, P.O. B. The law requires that the deatl ate has been signed by the atte page 2 should be detached for completed by Physicia	9 Unknown								22 2111				
ds, Faires that signed d be de	Part II. Other significant condit	ions contributing to de	eath but not resu	ılting in the u	inderlying ca	ause give	en in Part f					e to the cause of	
w require been s should leted									1(1)	res 2LX	No 3	Probably 4 🗌	Unknown
Il Records, The taw requires to sate has been signe page 2 should be completed by									24a. Was		24b. Were	autopsy findings to completion of	available
The tage page									perfo 1 ☐ Yes	rmed?	death	n? ′es 2□ No	
Vital F aician: Th s certificate lirector, pag	25. Was case referred to medica	al					26. Place	of Death	(Check only o				
~ × × ×	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	npatient 2 🗆 E	EP/Outpatie	nt 3 DO	A Othe	er: 4 🗆 Nu	rsing Ho	me 5 Resid	dence 6	□Other (S	Specify)	
on of ding Physics After this funeral dine; Total	27. Manner of Death	28a. Date	of Injury th, Day Year)	28b. Time o	f 2	8c. Injury Work	at at		28d. Describe I				
Division I or Attending after death. Diractor: After I in by the fune		tigation	, = , ,	,,	М		Yes 2□	No					
Divisic or Attancatter death Director: In by the	3 Suicide 6 Could 4 Homicide deten	mined 286. Place	of Injury - At hor	me, farm, st	reet, factory	, office			28f. Location (5 City or Tox		Number or	Rural Route Nun	nber,
Division c tal or Attanding P rs after death. at Diractor: After led in by the funers Certification;		Julian	ng, etc. (opocny	/					ony or vo.	, σιατο,			
To the Hospital within 24 hours a To the Funeral completely filled Medical Ce	29a. Certifier 1 Certifyi	ng Physician: To the	best of my know	wledge, deat	h occurred	at the tim	ne, date an	nd place,	and due to the	cause(s) a	ind manner	as stated.	,
the Hosp thin 24 hou or the Fune mpletely fill	(Check only 2 Medica one)	I Examiner: On the ba and man	ner stated.	ion and/or in	vestigation,	in my op	oinion, dea	ith occurr	ed at the time,	date and p	olace, and c	due to the cause(5)
Divine Hospital or within 24 hours after to the Funeral Diric completely filled in Medical Cert	29b. Signature and title of certifi	er	0		290		number					onth, Day, Year)	
15+1	Cerain	Alalnh	er			D4	3496		[March	22,	2007	
1-	30. Name and address of person	who completed caus	e of death (Item	23a) (Type,	Print)								
	Mohammad Khal					#70	0, Si	lver	Spring	, MD	2091	0	
State	31. Date filed (Month, Day, Year		egistrar's Signat										
Registrar	MAR 27	2007	gue di	400	No. 19								

	Physic		Decedent's Name (First, Middle, Last) SELMA MARIE JACKSON		2. Date of Death Month APRIL	Day 2007	3. Time of Death 2:00P
	/Med Exami		4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL BALTIMO			4c. County of Death	
	Funeral Director		5. Social Security Number 216=12=7519 6. Sex 1 M XXF 91 7. Age (In yrs. last birthday) Months Days Usual Residence of Decedent	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Sept. 23	9. Birthp Cour ,1915 Mary	place (State or Foreig ntry) yland
	Maryland a-f show	tor	10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Baltimore Co	County		1	10d. Inside City Limits
	ith with the 23a or 28	ral Dire	10e. Street and Number 10f. Zip Code 2212 Hazel Avenue 2	21206	10g.	Citizen of What Cour	ntry?
	5-0036 72 hours after death with the Maryland naturel', or items 23a or 28a-1 show also I Examinet must be accided at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of His If Yes, specify Cuban It Yes, Give Year or Dates: 13. Was Decedent of His If Yes, Specify Cuban It Yes, Sive Year or Dates:	ispanic Origin? (Spec in, Mexican, Puerto R Specify:	orly Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Bla	etc.
ટ	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examination to invitted at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. 15. Decedent's Education (Give kind of work done dt life. DO NOT use retired) Accountant/Boo	during most of working I)	⁹ A	o. Kind of Business/In CCOUNTING OOKKEEDING	&
elm	yland ould be file Mental Hygerked otheratic event,	To Be C	17. Father's Name (First, Middle, Last) Thomas R. Jackson		(First, Middle, Maid . Moorman	den Sumame)	
Sackson, Selma	e, Mar 1 and 2 sh Health and em 27 is m		19a. Informant's Name/Relationship (Type, Print) Carolyn Lassahn 20a. Method of Disposition 19b. Mailing Address (Street as 838 Luthardt F		nore, Mar		220
K50)	Baltimore, permit. Pages 1 a Department of Her Important: If item eny injury or other once.		1 Burial XXcremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Foneral Service Ligensee 22. Name and Address	Inc. 4-6-		ltimore, M	
Jac	Bal permi Depar impo impo		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line.	r Rd. Balt	imore. M	d. 21236	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. MyOCardial I	In far	tion		Onset and Death
	Box 68760, Control of the control of	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):	as e			
	. 0 00	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown		23d. Date of deliver	ery Day Year	
	cords, P.O. w requires that the dispensioned by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	en in Part I.		co use contribute to the	
	The law re rate has be page 2 sho	Completed	Hypothym.dism		24a. Was an autopsy performed	Drior to con	opsy findings available impletion of cause of
	Division of Vital Records, P.O To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	To Be	Hospital: 1 Inpatient 2 EP/Outpatient 3d DOA Other	4 Norsing Hom		6 ☐Other (Specifi	у)
	IVISION or Attending frer death. Nrector: Afte	Certification:	1 Matural 5 ☐ Pending (Month, Day Year) Injury Work! 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined (Month, Day Year) Injury Work! 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Yes 2 No	Bf. Location (Street City or Town, St	t and Number or Rura tate)	al Route Number,
	Hospital of 24 hours at Funeral Distriction	Medical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opi and manner stated.	ne, date and place, an	nd due to the cause d at the time, date	e(s) and manner as st and place, and due to	tated. o the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier 29c. License	number	29d.	Date signed (Month,	Dey, Year)

Registrar

OHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) APR 1 0 2007

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Terrance Baker MD 560 / Loch Raven Blvd. Baltimore 21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1242 2007 /Medical 4b, City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner Salisbur Hospice the Wicomico 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Days Hours Months Director 217-28-3075 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and it fitem 27 is marked other than "natural", or items 23a or 28a-f show ant: If tem 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director XUANTICO 1 COMICO 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? o e 6/35 14. Race - American Indian, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces Black, White, etc. Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK Specify: Completed by 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BOARD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHNSON 2 NHO LAWRENCE JEDRGIA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Date 20c. Location ATCH PENNY RD BERNARD JAMES-GRAND SON Important: If Item any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SPRINGHILL CEMETERY 3/28/07 22. Name and Address of Frcility 21. Signature of Funeral Service License BENNIE SMITH ST. SALISBURY, IMD 21801 ISABELIA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** KANCREATIL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, leave the line of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 mpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. 28d. Describe how injury occurred Injury at Work? After Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: completely filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4256 VAMES W 2180 S 30. Name an vadd ess of person who completed cause of death (Item 23a) (Type, Print) COUSTAL HOSTICE 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

2007

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2007 11347 1. For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day March 17, 2007 Medical Examiner 1105 hrs Gale Kozlowski 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Allegany 81 East Mechanic Street Apt 207 Frostburg 5. Social Security Number unk6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State orunk **Funeral** Hours Foreian Months Director 1 M 2 X F Nov 4, 1955 Country) 51 Yrs Usual Residence of Deceden 10d. Inside City Limits 10b. County 10c. City. Town or Location s 23a or 28a-f show e notified at once. 1 X Yes 2 X No 28a-f show Frostburg MD Allegany Director 10e Street and Number 10f. Zip Code 10g Citizen of What Country? 21532 81 E. Mechanic Street #207 USA Funeral 11 Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black. , or items 2 r must be r If Yes, specify Cuban, Mexican, Puerto Rican. etc.) Armed Forces? White, etc. 1 Never Married 2 Married unk Yes t; If item 27 is marked other than "natural", o other traumatic event, the Medical Examiner I 3 Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify. white Specify: \$ 16a. Decedent's Usual Occupation (Give kind of work done $rac{n}{k}$ 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Completed utimore, MD 21215-0036
iit Pages I and 2 should be filed within 72 hou riment of Health and Mental Hygiene.
rtant: If item 27 is mostless. during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk unk unk 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD 21201 O.C.M.E. 20a. Method of Disposition
1 Burial 2 Cremation 3 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place) Removal from State rtant; Cumberland Cremntery 2007 22. Name and Address of Facility Eichhorn McKenzie F.H., PA 8 E. Main St. Board 655 W. Baltimore 21201 Lonaconing, MD 21539 Baltimore, MD Part I. Enter the disease or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and ailure. List only one cause on each /Medical Death Immediate Cause (Final disease Diabetic ketoacidosis Examiner or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit d. sician/Medical g physician a s the burial - t X UNPENDED AMENDED a, 22, perFH, 23a, 27, perME, g866, 4/24/07 TT Box 68760, IF FEMALE: 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the the attending Ectopic pregnancy Month Year use as t Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. þ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, ficate has been si, page 2 should b 24h. Were autonsy findings available 24a Was an autopsy prior to completion of cause of performed? certificate ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician; within 24 hours after death. director, 25. Was case referred to medical 26.Place of Death (Check only one) of Vital 8 Hospitai: 1 Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Othor: Scene After this 1 🗸 Yes 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: 1 X Natural Division 5 Pending To the Funeral Director: completely filled in by the Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide determined Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) March 19, 2007 O.C.M.E Ma 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2007

ORIGINAL

Box 68760 P.O. Records, Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director.

29b. Signature and title of certifier Moono 29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print) Zeba S. Geloo, MD Hirsh Health Center

DOD 61934 31261 W 1801 E. Jeffersm St. 3/26/07 Rockville, MD m St. 20852

31. Date filed (Month, Day, Year) State

4 | Homicide

29a. Certifier

Registrar's Signature



Registrar

			1 - For State Registrar	State of	Marylar		artment rtificate			and Me		giene leg. No	211117	11349
ľ	Dhusiai	į.	1. Decedent's Name (First, Middle, La.	st)							2. Date of Dea Month	th Da	y Year	3. Time of Death
	Physici /Medic		Delores Elai:	ne Lindsa	ay					1	April 5		007	1:24 P.M.
	Examir		4a. Facility Name (If not institution, give	e street and numb	er)		4b. City,	Town, or	Location of	f Death		4c.	County of Death	
	, g	.	7 Redwood Cir					_	ersto				Washi	ngton
П	Funeral		5. Social Security Number 6. S	ex 7. □M 2∏rF	Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs.	8. Date of Birth (Month, Day	Year)	9. Birth.	place (State or Foreign intry)
	Director		218-40-4199 Usual Residence of Decedent		64	Yrs.					April 2		1942	Maryland
	and		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	Many	ō	Maryland Washin	aton			7.7			_				1 ☐ Yes 2 ☑ No
	28a	rec	10e. Street and Number	9 0011			10f. Zip		stown	1	1	Oa. Cit	izen of What Cou	intry?
	h with	0	7 Redwood Ci	rcle				21	740				U.S.A.	,
	death	Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U	.S. 13. \	Was Deced	ent of His	spanic Orig	gin? (Spec	ify Yes or No- ican, etc.)		14. Race - Ameri	
9	after or its	Fu	1 ☐ Never Married 2 【XMarried	Armed Force	No No		_			, Puerto R	ican, etc.)		Black, White,	, etc.
9	72 hours after death with the Maryland natural', or Iteme 23e or 28e-f show dical Examination must be motified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Date	os:		1 ☐ Yes 2	X 140	Specify:			,	Specify: N	Mhite
21215-0036	"natu	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced (Give	kind of won	k done di	urina most	of working	9	16b. Ki	nd of Business/In	ndustry
12	withir ane. than	шр	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. L	DO NOT us	,					** . 7 .	
	Hygie Hygie ther int,		9 17. Father's Name (First, Middle, Last)				пош	ecar		do Maria	First, Middle, i	de ide e	Healt	h
an	d be antal	Be c	David P. Hawth	orno									Sumame)	
Maryland	shoul nd Me mark mati	2	19a. Informant's Name/Relationship (19h Mailin	a Address	(Stroot at			d Godla		r Town, State, Zip	- 0-4-1
<u>S</u>	od 2 stranger tranger		Raymond Lindsay	(Husba	and)								yland 21	
ē,	s 1 au f Hea item othe		20a. Method of Disposition	, , , , , , , , , , , , , , , , , , , ,	20b. P	lace of Dispo-	sition (Nam	e of	.]	Da			cation - City or To	
Ë	Page ent o nt: if ry or			1 □ Burial 2 ▼ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cemetery, ciematory or other place) April 7, Smithsburg Crematory 2007 Smithsburg									thsbura.	Maruland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23e or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licen				. Name and		_		-		s Funera	
ä	Depa Impo any is		Tolke or	Davis	MO	1414 1.	2525	Bradi	bury	Ave.	Smiths	bur	s runera q, Marul	and 21783
		1	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caus	sed the death									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pas	COA	tic	CANC	0 5						Onset and Death
	/Medical		resulting in death)	Due to (or	as a consequ	uence of):	Cijiic	~_						71010100
	Examiner		Sequentially list conditions,	b										
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	uence of):								
_	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	xan	that initiated events resulting in death) Last	c	as a consequ	ience of):								
8760,	be e sicien buria	alE		240 (0 (0)	ao a comocq.	201100 01).								
687	ficate phys s the	edlcal		d										
Box	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. if yes, outcon	ne of pregna	ncy							12d Date of deliver	
m	death a atte	clai	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant			Ectopic pre-						23d. Date of delive Month	Day Year
O.	t the by the ache	hys	9 □Unknown	9□ Unknown										
	res that the de igned by the a be detached f	by P	Part II. Other significant conditions co	entributing to death	but not resu	ulting in the un	derlying car	use given	n in Part I.		23e. Did tob	acco u	se contribute to th	ne cause of death?
Records,	w require been sig	pa									1 ☐ Ye	s 2	\$No 3 □ Prob	pably 4 □Unknown
ပ္ပ	law ras be	Completed									24a. Was ar		24b. Were auto	psy findings available
<u> </u>		E C									autops perform		death?	mpletion of cause of 2 ☐ No
Vital	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?						26. Place o	of Death (Check only on		12.00	
0	hys this al di	ို	1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpa		ER/Outpatient			4 🔲 Nurs	sing Home	5 Reside	nce 6	Other (Specify	y)
	ing ffe and	ü	27. Manner of Death 1 ★ Natural 5 □ Pending	28a. Date of Ir (Month, L	jury Day Yeer)	28b. Time of Injury		c. Injury a Work?			d. Describe ho	w injury	occurred .	
<u>s</u>	Attending Physician: r death. ector: After this certific by the funeral director,	cat	2 Accident investigation 3 Suicide 6 Could not be	20 51 (1			М		es 2 No					
Division	after Direction by	Certification:	4 Homicide determined	28e. Place of I building,	etc. (Specify	me, farm, stre	et, factory,	office		28	t. Location (Sti City or Town	eet and , State)	d Number or Rura	I Route Number,
	spita nours neral filled	S	29a. Certifier 1 Certifying Phy	sician: To the be	st of my know	vledne death	occurred at	t the time	date and	place and	d due to the se			
	1 24 h	edical	(Check only 2 Medical Exam	iner: On the basis and manner	or examinat	ion and/or inv	estigation, i	n my opir	nion, death	occurred	at the time, da	ite and	place, and due to	tated. the cause(s)
	To the Hospital or Attandi within 24 hours after death To the Funeral Director: A completely filled in by the t	Me	29b. Signature and title of certifier				29c.	License r	number		29	d. Date	signed (Month,	Dey, Year)
			1 Ston Al	lebers	M)	J) 2	+44	47		Ac	2016,	2007
			30. Name and address of person who c	ompleted case of	death (Item	23a) (Type, P	Print)					, ,		
	1		Steven Ludgen	Hatteb	elg	Hobin	WOO	IM	terna	. Mea	dicine	. Ho	19Crstown	, M. 21742
2	Stat Registra	-	31. Date filed (Month, Day, Year) APR 1 0 200	7 22. Regis	strar's Signat	ure								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 23, 2007 **Physician** 9:36 P M Schultz Lisser Martha March /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death **Examiner** 4701 Willard Avenue, Apt. 1602 Chevy Chase Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Jan. 20, 1924 9. Birthplace (State or Foreign New York 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 X F Months Days Hours 095-16-4107 83 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 12 should be filed within 12 mounts.

th and Mental Hygiene.

77 Is marked other than "natural", or Items 23a or 28a-f show

17 Is marked other than "natural", or Items 23a or 28a-f show

17 Is marked other than "natural", or Items 23a or 28a-f show 10a, State 10b. County Maryland | Montgomery Chevy Chase 1 Zes 2 □ No Directo 10e. Street and Number 10g. Citizen of What Country? 20815 United States 4701 Willard Avenue, #1602 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White altimore, Maryland 21215-0036 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Administrator Elementary School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Schultz Julia Finestone Joseph 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau
once. Morton S. Lisser -husband 4701 Willard Avenue,#1602 Chevy Chase, Maryland20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 3/26/2007 Garden of Remembrance Clarksburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA Horald 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Pancreas Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? es 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ospital or Attending Physhours after death.
uneral Director: After this ly filled in by the funeral di this 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I Hospital 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed sause of death (Item 23a) (Type, Print)



Registrar

D05346

March 25, 2007

			For State Registrar	State o	of Marylan		artment of H		nd Me		giene Reg. No.	2007	terrior display	351
*		45	Decedent's Name (First, Middle, I	Last)					2	2. Date of Dea	ath		3. Time of	Death
	Physici /Medic		Carrie Foy	Moore	r				N	Month Iarch	22 , 2	.007 Year	3:05	\mathbf{A}^{M}
	Examin		4a. Facility Name (If not institution, g	ive street and nu	mber)		4b. City, Town, c	r Location of				County of Death		
			9707 Old Georg	etown Rd	#1509		Bethese					ntgomer	у	
	Funeral		Social Security Number 6	. Sex 1 □ M 2 1 F	7. Age (In yrs.		If Under 1 Year Months Days	if Under 24	Min.	B. Date of Birt (Month, Da	v. Year)	Coun	lace (State or try)	
ile.	Director		553-68-6483 Usual Residence of Decedent		92	Yrs.			5	Sept.	9,191	4 Eufa	ula, A	L
	and w		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					1	0d. Inside Cit	y Limits
	Mary f sho ied a	io	Maryland Montgo	30 KV	Ro	thesda							1 🛮 Yes	2 No
	r 28a	Director	10e. Street and Number	пету	DE	tilesua	10f. Zip Code				10g. Citize	en of What Cour	itry?	
	death with the Maryland ms 23a or 28a-f show r must be notified at	ĮE	9707 01d George	etown Rd	#1509		2081	4			U.S	. Α .		
	ms 2	Funeral	11. Marital Status		edent Ever in U.	.S. 13.	Was Decedent of H		in? (Speci	ify Yes or No		4. Race - Americ		
٥	after or ite	F	1 ☐ Never Married 2 ☐ Married		21 No		il Tes, specily Cub 1 □ Yes 2 🛣 No		rueito ni	ican, etc.)		Black, White,	etc.	
2	ours iral", Exa	d by	3 AWidowed 4 ☐ Divorced	Year or D	Dates:		1 1 1 63 2 2 2 1 1 0	Opecity.			,	Specify: Wh:	ite	
1215-0036	within 72 hours after ene. than "natural", or ite he Medical Examine	Completed	15. Decedent's (Specify only highest)	Education grade completed)		16a. Dece	dent's Usual Occup kind of work done OO NOT use retire	pation during most of	of working	, []	16b. Kind	d of Business/Ind	dustry	
7	within sne.	ᇤ	Elementary/Secondary (0-12)	College (1-4or 5+)		_	(d)			0			
Z	Hygie Ther I		17. Father's Name (First, Middle, La			HOI	nemaker	18. Mother	's Name (First, Middle,		n Home		
and	d be i	Be C	Humphrey Foy	0.17				Mary	_ `		, , , a , a , a , a , a , a , a , a , a	ourname)		
<u></u>	2 should be filed w n and Mental Hygie Is marked other t raumatic event, th	욘	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street	· · · · · · · · ·			er. City or	Town, State, Zip	Code)	
	l and 2 sealth an m 27 is her trau		Richard Foy Moor	rer		7221	MacArthu	ır Blyd	1. Re	theeds	ı. Ma	rvland 2	20816	
saitimore,			20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of natory or other pla	ce)	Da			ation - City or To		
Ê	Pages nent of int: If its iry or o		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State		n Nat'l (227 3	2007	Arli	natan - T	7.0	
<u>=</u>	permit. Pag Department Important: I any Injury o	1 1	21. Signature of Funeral Service Lice		I AL	22	2. Name and Addre	ess of Facility	Jose	ph Gav	vler	s Sons,	Inc.	
ñ	an In De	0.00	Williamy 10	Bug	al_	5	130 Wisco	onsin A	Ave.	N.W. V	Vashi	ngton D	.c. 20	016
H			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that	caused the deat	h. Do not ent	er the mode of dyi	ng, such as c	cardiac or	respiratory a	rest,		Approximate Interval Bety) ween
	Physician		immediate Cause (Final disease or condition				Failure						Onset and D	leath
,	/Medical		resulting in death)		(or as a conseq		Tarrare							
	Examiner		Sequentially list conditions,	D.	tic Ste									
	D tis	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to	or as a conseq	uence of):								
	and -trans	хаш	that initiated events resulting in death) Last	c	(or as a conseq	ulance of):								
8/60,	cate be executed physician and the burial-transit			Duc to	(01 45 4 0011500	querios orj.								
2	icate phys s the	dical		d										
ROX	death certifica attending ph	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome pf <u>pr</u> egna	ancy					23	3d. Date of delive	erv	
ň	death e atten ed for u	icial	in the past 12 months? 1 ☐ Yes 2 ☒No	4□Preg	birth 2□Feta nant at time of d]Ectopic pregnanc] Other <i>(specify)</i> _	У				Month	,	/ear
5	t the	hys	9 ☐ Unknown	9□Unkr	nown									
ν, T	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions	s contributing to d	leath but not res	ulting in the u	nderlying cause giv	ven in Part I.		23e. Did to	bacco us	se contribute to the	ne cause of d	eath?
cord	en sig	ed								101	res 2□] No 3 ☐ Prob	ably 4 🔀 U	Inknown
ပ္ပ	has be	Completed								24a. Was		24b. Were auto	psy findings a mpletion of ca	available
r	0 5 0	E O									rmed? 2 ☑ No	death?	2□No	1030 01
VITall	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Lance to the same				26. Place of	of Death (Check only o				
20	Physician: this certific ral director,	2	1 ☐ Yes 2 🔼 No		Inpatient 2			4 LI Nurs				☐Other (Specif	y)	
Ē	dlng P J. After t funera	ino	27. Manner of Death 1 Anatural 5 Pending		of Injury oth, Day Year)	28b. Time o Injury	Wo			3d. Describe I	now injury	occurred		
VISION	tend leath tor: /	cati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	ho .	a afinium. At he			Yes 2 □ N	_	N. 11' //	74		1.D	
₹	pital or Attenous after death ours after death leral Director:	Certification:	4 ☐ Homicide determine	d Zoe. Flace	ling, etc. (Specit	fy)	eet, factory, office		20	City or Tov	vn, State)	Number or Rura	u noute rvum	per,
_	spital ours a leral filled	2	29a. Certifier 1X Certifying	Physician: To th	e best of my kno	owledge, deat	h occurred at the ti	ime, date and	d place, an	nd due to the	cause(s) a	and manner as s	tated	
	e Hos 124 hc ie Fun	ledical		caminer: On the b	pasis of examina	ation and/or in	vestigation, in my	opinion, deatl	h occurred	d at the time,	date and	place, and due to	the cause(s)
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Me	29b. Signature and title of certified	0			29c. Licens					signed (Month,		
	12		> Sun t.	Miss	MM	D	010	10395	533	/VA	031	12312	007	
•	1		30. Name and address of person wh		se of death (Iten	n 23a) (Type,	Print)							
				son mi	- 090		onsin Av	enue;	Beth	esda.	MD 2	20889		
I	Sta		31. Date filed (Month, Day, Year)	2007	gistrar's Signa	- 4								
	Registi	ar	MAR 27	7001	William.	SU SA	A PROPERTY.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND#19aperFH3/29/07, EMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 24, 2007 7:50pm Carol Anne Malik March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 9890 Washingtonian Blvd. #712 Montgomery Gaithersburg If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 27, 1946 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 □ XF 60 102-36-6869 Florida **Director** Usual Residence of Decedent 10d. Inside City Limits r 28a-f show notified at 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Director MD Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be a 9890 Washingtonian Blvd. #712 20878 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Medical Scheduler July be file. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important; If Item 27 is marked any injury or other traumatic ev Frank J. Drogan Leona A. Kruczko ပ 19a. Informant's Name/Relationship (*Type. Print*) Augustine Heather Augustine (Da 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1425 Thoroughbred Trail Parkton, NC 28371 (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 26, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Md. Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Euneral Service Licens obvite 10 East Deer Park Dr. Gaithersburg, Md. 20877 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Endometrial Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical The law requires that the death certificate 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes ∑☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1□ Yes 2 No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 21X No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

P.O. Box 68760. Division or Vital Records,

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: ' 44 hours after death. Funeral Director: After this certifica filled in by To the Hospital within 24 hours a To the Funeral C

10

2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one)

29b. Signature and title of certifier

29c. License number

D54378

29d. Date signed (Month, Day, Year)

March 26, 2007

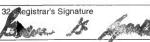
and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type-Print)
Dr. Cheryl Aylesworth M.D. 2730 Unvers 2730 Unversity Blvd. West #400 Wheaton, Md. 20902

State Registrar

completely

31. Date filed (Month, Day, Year) 2007 MAR 27



DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 2 7 2007

32. Registrar's Signature

			State of Maryland / Department of Health and 1-State Registra MEND#10c+19cperFH3/29/07, BM. McCo Certificate of Death		giene) / /	11354						
	Physici	an	Month Day Xear									
>	/Medic Examin	al	Linda Moore Navas 4a. Facility Name (If not institution, give street and number) 8204 Woburn Abbey Road 4b. City, Town, or Location of Deat Glenn Dale	4c. County of Dea Prince	11:21 P.M							
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs									
	Director		278-46-2479 1 M 2 XF 57 Yrs. Months Days Hours Min	8. Date of Birth Day JULY 19	,1949 Oh	thplace (State or Foreign puntry) LO						
	a-f ahow	ctor	10a. State 10b. County Glenn Late Maryland Prince George's Glenn Late - Glenn Late		10d. Inside City Limits 1 ☐ Yes 2 🛣 No							
	th with the 23a or 28a and be not	by Funeral Director	10e. Street and Number 8204 Woburn Abbey Road 10f. Zip Code 20769		10g. Citizen of What Co United Si							
9036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural; or Iteme 23a or 28a-f ahow eny injury or other traumatic avent. The Medical Examinating must be notified at once.		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer Yes, Give Year or Dates:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi							
15-0	iin 72 h	Completed	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of wo life. DO NOT use retired)	rking	16b. Kind of Business	/Industry						
1212	filed with Hygiene other tha	To Be Com	Elementary/Secondary (0-12) College (1-40 5+) Editor 17. Father's Name (First, Middle, Last) 18. Mother's Na		Print Journ	nalism						
/lanc	uld be fi Mental H Irked ot				e, Maiden Surname) ne Currey							
Baltimore, Maryland 21215-0036	end 2 should lead that and Men n 27 la marke		19a. Informant's Name/Relationship (Type, Print) George Ernest Navas -husband 19b. Mailing Address (Street and Number or Right) 8204 Woburn Abbey Roa	ural Griefilmbe d-Glen-D	panyer Town, State, ale, Maryla	zip Code) and 20769						
	Pages 1 (ment of He tant: If Item		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 3/	1	Alexandria	Oc. Location - City or Town, State lexandria, Virginia						
Ball	permit. Departi Import eny inj		21. Signature of Funeral Service Licensee Lonald V. Bargurant 4400 Powder Mill	dt Funera Road Beli	al Home, PA tsville, Ma	ryland20705						
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Breast Cancer Due to (or as a consequence of):	c or respiratory ar	rest,	Approximate Interval Between Onset and Death						
	tificate be executed g physicien and as the burial-transit	Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):									
P.O. Box 68760,	Attending Physicien: The law requires that the death certificate or death. If death. ector: After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the		d. IF FEMALE: 23b. Was decedent pregnant in the past 12 conths? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of de Month	livery Day Year						
rds, P	equires thet an signed b ould be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		id tobacco use contribute to the cause of death? □ Yes 2 □ No 3 □ Probably 4 🖔 Unknow							
Division of Vital Records,	t: The law re icete has be r, page 2 sho			24a. Was : autop perfor 1 ☐ Yes	topsy prior to completion of cause of							
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ion o	To the Hospital or Attending Physicien: The lawithin 24 hours effer death. To the Funeral Director: Affer this certificete has completely filled in by the funeral director, page 2	atlon; To	27. Magner of Death 1 ②Natural 5 □ Pending (Month, Day Year) 28b. Time of Injury 2 28b. Time of Injury 3 28c. Injury at Work? 2 □ Accident investigation M 1 □ Yes 2 □ No	28d. Describe how injury occurred								
DIX:	s efter der s efter de al Directo ed in by ti	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	na Hospital or n 24 hours effe na Funeral Dir sletely filled in I	edical C	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and occurred at the time, date and place 2 Medical Examiner: On the basis of examination and occurred at the time, date and place 2 Medical Examiner: On the basis of examination and occurred at the time, date and place 2 Medical Examiner: On the basis of examination and occurred at the time, date and place 2 Medical Examiner: On the basis of examination and occurred at the time, date and the basis of examination and occurred at the time, date and the basis of examination and occurred at the time at the basis of examination and occurred at the time at the basis of examination and occurred at the basis of examination at the basis of examination at the basis of examination at the basis of examination at the basis	a, and due to the curred at the time, o	cause(s) and manner a date and place, and due	s stated. a to the cause(s)						
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number	:	29d. Date signed (Month, Day, Year)							
~	20		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary Wilks, M.D. 10200 Old Columbia Road Columbia, Mar	1 101	March 26,	2007						
			Gary Wilks, M.D. 10200 Old Columbia Road Columbia, Mar 31. Date filed (Month, Day, Year) 32 Registrar's Signature	yland 21	046							
	Sta Registr		MAR 2 7 2007									

			For State		State of	of Marylan					nd M		20	07	11056		
		1. Decedent's Name (First, Middle, Last)								ertificate of Death				Reg. No.			
	Physicia	an		rst, Middle, La								2. Date of Death Month Day		Year	3. Time of Death		
	/Medic		Leigh	Anne		Prochno	W					March			6:12 P ^M		
	Examin	er	4a. Facility Name (If not			ımber)		4b. City, Town, or Location of Death						y of Death			
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	Funeral		5. Social Security Numb	1	ex □M2√2F	7. Age (In yrs.	1/		Days	Hours	Min.	8. Date of Birth (Month, Day,		Coun			
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Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		1 Never Married 3 Widowed 4		Armed F	orces? 2 ⊡x No ive		fYes, specify I∐Yes 2☐	y Cubar	Specify:	Puerto	Rican, etc.)	BI	ack, White, of the white, of the white of th	etc.		
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	12		30. Name and address 7113 Wood1						209	12 A	ndra	ew Putna	m. M.T).			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM 123a, Par PHYS. G866.4/10/07 WS
State of Marytand Pepartment of Health and Mental Hygiene, 17 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month Yeer **Physician** April 2007 11:52 Lloyd Wayne Roman A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Hancock 539 North Pennsylvania Avenue If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months 1949 WV June 14, Director <u> 212-50-8813</u> Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County Show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heath and Mental Hygiene. and them to 1 tems 23 sor 28a or 28a-1 show ant; if Item 27 is marked other than "natural; or Items 23a or 28a-1 show ury or other traumatic event, the Medical Example at must be rediffed at 1 Yes 2 No Director Hancock MD Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21750 USA 539 North Pennsylvania Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: 2 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Auto Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Parts Remanufacture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ္ Lloyd L. Roman <u>Marguerite R. Yonker</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 539 N. Pennsylvania Avenue Hancock, MD 21750 Marjorie A.Roman/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Pages Department of Important: If II any injury or c 04/05/07 Antioch Christian Big Cove Tannery, FA 21 Signature of Funeral Service Lic 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368
t enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death
Onset and Death व 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. End. Stage Renal Disease Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Congestive Heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnent at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 1 ☐ Yes 2 No 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2**V** No To the Hospital or Attending Physician: After this certification funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 ANO 3□ DOA ဥ this 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 5 Pending investigation 1 Salatural s after decreal Director: After 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined within 24 hours after dea To the Funeral Directo completely filled in by th 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12931 AVENUE MAGERSTOWN MD 21742 CAUHILL 32 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 09 Registrar 2007

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lichael Ross, S		1- For State Registrar	tate of Maryla		artment o		and Me		R	eg. No.][7 1135
Physici Medical Exam		1. Decedent's Name (First, Midd Michael Ro	ss Sr						Date of Dea Month April 3, 20	Day Ye	ar	3. Time of Death 0020 hrs
and a		4a. Facility Name (if not institution Washington County H	4b. City, Town Hagersto		ion of Death		4c. County of Death Washington					
Funeral		5. Social Security Number	If Under 1 \		Jnder 24Hrs. 8	. Date of Bir	th (MM/DD/YYY)					
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darylar 28a-f s	Director	10e. Street and Number			Hagerstown 10f. Zip Code				10g. Citizen of What Co			ntry?
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215-0036 be filed within 72 hours after death with the Maryland mal Hygiens Head other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 M	farried Armed F	Lowering		Vas Decedent of Yes, specify Cu					e, etc.	can Indian, Black,
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	Charles Certifying F	aminer: On the basis and manner:	of examination	and/or investig	gation, in my opi	nion, death	h occurred at th	e time, date	and place, and	due to th	e cause(s)
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Registrar

ORIGINAL

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certificate be executed burial-trar and Box 68760, physician the as nding nse atten for 1 detached Records, P.O. the peen page 2 s has

State
Registrar AMFND#20bperFH3/28/07, BMW, McCo 1. Decedent's Name (First, Middle, Last) 3 Time of Death .^{Day}2007 March 23, **Physician** Helen R. Somarriba 4:13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 919 Snure Road Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 23, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 1 F New Jersey 579-08-3579 33 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f sh Examiner πust be notified 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20901 items 23a 919 Snure Road IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 K Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 Yes 2□ No Specify: Nicaraquanoecity: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) Callege (1-4or 5+) Teacher's Aide Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental and 2 should be Edwin I. Somarriba Offelia T. Molina ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: if Item 27 is
any injury or other trau Edwin I. Somarriba/Father 919 Snure Road, Silver Spring, MD 20901 Date 28 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c Location - City or Town, State 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State March 27 Rock Creek Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Washington, DC 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd, W, Silver Spring, Md 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1 Year Ovarian Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 2 ER/Outpatient 3 DOA 1 🗌 Yes 1 Inpatient ၉ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 Tes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🔀 Certifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D33224 March 26, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1400 Forest Glen Road, #435, Silver Spring, MD 20910 Ram S. Trehan, M.D. egistrar's Signature 31. Date filed (Month, Day, Year) State MAR 27 2007

Registrar

Karen Shprintz Grossn	ıan
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State of Maryland /	Department of He	ealth and Men	tal Hygiene

	1- For State Registrar			Certific	ate of	Death			Reg. No		0 1	1100
Physician/	1. Decedent's Nam	e (First, Middle,I	ast)	PRINTZ-G	ROSSN	(AN		Date of Month	Death Day	Year		Time of Death
Medical Examine								March	23, 200	7		2112 hrs
	4a. Facility Name (Surburban I		give street and numb	er)	4	b. City, Town, o Bethesda	or Location o	of Death	1	ic. County of Montgom		
Funeral	5. Social Security N	lumber 6	Sex 7.	Age (In yrs. last bir	thday)	If Under 1 Ye		er 24Hrs. 8. Date of		1		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Certification: To Be Completed by Physician/Medical Executions	(Check only 1 one) 2		sician: To the best o iner:On the basis of e and manner state	examination and/or	investigat	red at the time, ion, in my opinio	on, death oc	ace, and due to the courred at the time,	date and p	lace, and du	ue to the c	ause(s)
2	29b. Signature and	title of certifier	and mainer state	n _A		29c. Lice	nse number		29d	l. Date signe	d (Month	, Day, Year)
(0)	XI	18	UX	\ \		0.0	C.M.E.		Ma	arch 24, 2	2007	
	30. Name and add	ress of person w	ho completed cause of	of death (Item 23a)					1			
	Susan Hog		ssistant Medical		11 Pen	n Street, Ba	altimore, I	MD 21201				
Stat		ARay2'ery) 2		strar's Signature	Spanier	A s						
Registra	12			Me St.	A CHANGE	A CONTRACTOR OF THE PARTY OF TH						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** Semeler Senior 2315 Juseph */Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Hospice at the Lake Salisbur If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Year) 1 X M 2 ☐ F Days Hours Min Yrs 214-28-7998 1-11-1934 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show 1 ☐ Yes 2 1 No Director MD Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or USA 21804 Funeral 813 Outten Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing 5 Glass Glazer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Frances Graham Anthony Semeler, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 813 Outten Road, Salisbury, Maryland 21804 Karen Beauchamp - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 3-27-07 Crematory of Delmarva Delmar, Delaware 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part1. Enter the disease, or compocations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a conse l'enc-foi): Physician /Medical Examiner Sequentially list conditions it use. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical as IF FEMALE: for use a 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 ☐ Unknown signed by t Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 12 Yes hun 2 No 3 Probably 4 Unknown page 2 should Completed peen 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No has certificate 1□ Yes Physician: 25. Was case referred to medical Was case examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Impatient 2 ER/Outpatient 3 DOA 2 4 ☐ Nursing Home 5 ☐ Residence _ 6 ☐ Other (Specify) this 27. Manner of Ceath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Pi within 24 hours after death.

To the Funeral Director: After the Completely filled in by the funeral Certification: 5 ☐ Pending investigation T⊠Natural 2 ☐ Accident (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year)

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause (OZLeel).

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ocestal

of death (Item 23a) (Type, Print)

D26278

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTFM#17, 18 per FH, G866, 4/10/07 WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 200^{Year} **Physician** James E. Wilson, III 11:25 aw April 3, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
March 1,1929 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1X M 2 □ F Maryland Yrs. 218-20-9069 78 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 21 No Harford Director Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4219 Webster Road 21078 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Supervisor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lois W. Wilson (Spouse) 4219 Webster Road, Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State Harford Mem. Gdns. Aberdeen, Maryland 3/6/07 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.

Abordeen. Maryland 21001-3399 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that Jaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ or Vital Records, 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Division or Attending 1 A hatural 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral L Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 140062765 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) U Chesapeake Dr. Bel. D.O. 500 Up Kurtom Nesseen 31. Date filed (Month, Day, Year) APR 1 0 2007 Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Year **Physician** March 21, Henry Harcus Work 7:45 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4986 Sentinel Drive # 504 Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Yea NOV • 11 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** , 1911 New York Days 1 XM 2 ☐ F Months 95 Yrs 402-42-1626 **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show iral", or items 23a or 28a-f shor Exa⊓iner must be notified at Maryland Montgomery Bethesda Director 1 □XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4986 Sentinel Drive #504 20816 United States · death v Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Intell than "natural", or ite marked other than "natural", or ite ury or other traumafte event, the Medical Examine ury or other traumafte event, the Medical Examine 1 ☑ Yes 2 ☐ No If Yes, Give 1942–1945 Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: \$ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Child Psychiatrist Medical 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Harcus Work Jeanette Harcus 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Nancy Wasell Work/ Wife 4986 Sentinel Dr. #504, Bethesda, MD 20816 20b. Place of Disposition (Name of cemetery, crematory or other place).

Geo. Wash. University March 21 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4

Donation 5 ☐ Other (Specify) Washington, D.C. Medical Center Signature of Funeral Service License 22. Name and Address of Facility Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Pneumonia one week /Medical Due to (or as a consequence of): Examiner Laryngeal dysfunction 5 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) a□Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an Was autopsy performed? Ves 2 No page certificate 1□ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident within 24 hours at er death

To the Funeral Director:
completely filled i by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

D22599

Wisconsin Ave #930; Chevy Chase, MD

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32 Registrar's Signature

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e and address of person who completed cause of death (Item 23a) (Type, Print)

Larsen,

2007

Ylene A.

MAR 27

91. Date filed (Month, Day, Year)

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death March 25 Day 2007 Year Physician 1:15 ам Bray White Gladvs /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Montgomery General Hospital Olney If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 □ F Yrs. Director March 18, 1917 West Virginia 90 577-07-7370 Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location show notified at 1 ☐ Yes 2√ No Director Maryland Montgomery Silver Spring 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or the Medical Examiner must be USA 20906 15121 Glade Drive, Apt. 2E Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: SpecifWhite þ 3 Nidowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygic Important: If item 27 is marked other 1 any injury or other traumatic event, # 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nora Blankenship Lonnie Bray ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15101 Interlachen Drive, #316, Silver Spring, MD 20006 Sharon R. White/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State Metropolitan Crematory March 26 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licenses 22 Name and Address of Facilities Funeral Home Inc. Silver Spring, MD 20901 500 University Blvd, W, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final disease or condition -3 wee Pheumonia Physician disease or condition /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar Due to (or as a consequence of): attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: thin 24 hours a To the within 2

State Registrar

Medical

29a. Certifier

30. Name and

29b. Signature and title of certifier

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Year)

and manner stated.

ddress of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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29c. License number

29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 1-For Stat Amend #5 Per FH C868 6/06 #007 icate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ April 2, 2007 Medical Examiner 0753 hrs Lucille Lynnette Wilson 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Easton Memorial Hospital Easton Talbot If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. 8 inthiblace (State or 7. Age (In vrs. last birthday) Funeral 2184cia 66cu 84195ber Hours Months Days Director Country Maryland 214-04-1106 2 X F 50 1 M Yrs 09-07-1956 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1X Yes 2 No 28a-f shov once. Talbot death with the Maryland Maryland Easton Director 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country notified at 36 West Street 21601 USA 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black 12, Was Decedent Ever in U.S. must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 X Never Married 2 Married Yes and 2 should be filed within 72 hours after If Yes, Give Year Widowed Divorced Yes 2X No specify Specify **Black** \$ 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical Supervisor Hardee 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be and Mental Mary E. Wilson Montro Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Palmer Golton Drive. Easton, Maryland Denise 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) other 1 X Burial 2 Cremation 3 Removal from State Pages 1 Department mportant: Woodlawn Cemetery 04/10/07 Donation 5 Other Specify Easton, Maryland 0 21. Signature of Funeral Service License 22 Name and Address of Facility Bennie Smith Funeral Home 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transi Physician/Medical X UNPENDED AMENDED PII, 27, perME g866. 4/11/07 TT Box 68760. 23d Date of deliver 23c. If yes, outcome of pregnancy the 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Dav Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. ģ Yes 2 ✔ No 3 Probably 4 Unknown Cocaine use Completed of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? certificate page ✔ Yes 2 1 🗸 Yes Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Other₄ examiner? Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 this 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day, Year) After 28b. Time of Injury 1 X Natural Division 1 Yes 2 No Pending death. Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated igrature and title officertifie 29c. License number 29d. Date signed (Month, Day, Year) April 3, 2007 O.C.M.E. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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Registrar

AFR 0 6 2007

SE SECOND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** MARCH 23 2009 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner omic 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country), **Funeral** Days Min 1 □ M 02 Director INIC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 19d. Inside City Limits 28a-f show notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or any inJury or other traumatic event, the Medical Examiner must be a Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 2 Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sate, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2330 ama anter 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place, 3 Removal from State 1 ☑ Burial 2 ☐ Cremation Family 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
1618 Wash Rd. Salisbr. 21. Signature of Funeral Service License LEWIS WATSON 23 Fart1. Enter the sease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 9CVD Physician /Medical Due to (or as a consequence of): Examiner ESRO Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9☐Unknown 9 ☐ Unknown ate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 20 No certificate Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 2 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

100 E CARROLL 1.0 egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3-24-2007

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. (_ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 10:00 AM Apri 2007 Laiba Asif /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital of 13aH more Baltmore Sinai 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min 1 M M F N/A Director 3 04 05 07 MD Usual Residence of Decedent la or 28a-f show t be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 510 Gwynnwest Road 21135 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Asian 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Asif Ayub Aliya Asif 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 Asif Ayub-Father Gwynnwest Road, Reisterstown, Md 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 4/6/07 Randallstown, Md 21 Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. P. 11. Enter the disease, or complications that vaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s. ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immeriate Cause (Final Pre Physician Ma dise se or condition resulting in death) turi /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the at Id be detached fo ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been si should I Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No has autopsy To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 1 Depatient ည 1 🗌 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Natural Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🖟 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) trice 00 V e 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 0103AM APRIL 09 2007 noma /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day 10-3-17) AG NES SAINT HOSPITAL Age (In yrs. last birthday)

57

Yrs. 9. Birthplace (State or Foreign Social Security Number **Funeral** Months 1 M 2 □ F 213-52-2628 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State City, Town or Location 1 □Yes 2 No atonsville Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify. Be Completed by Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nore Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Rural Route Number City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or 19a. Informant's Name/Relationship utonsuille, MDZ1228 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 4 □ Dopation 2 Cremation 3 Removal from State timore 5 Other (Specify) 21. Signature of Funer Service Licensee Dultimore, MD 2/229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he dialiure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) infarction MYOLARdia **Physician** MENOWA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed for use as the burial-trar attending physician and Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 🗌 No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No 1∐ Yes **Division or Vital** To the Hospital or Attending Physician: 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 PER/Outpatient 3□ DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Matural (Month, Day Year) Injury 5 ☐ Pending investigation 1 🗌 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Mi) who completed cause of death (Item 23a) (Type, Print)
- (CK, MD) 900 Caton Avenue 30. Name and address of person Battimore, Maryland J on 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For Stete Registrat Certificate of Death 2 Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Year **Physician** 6:45/th 9-5M 00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Imore 1-11zaketh UNSING ent If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 22 F 254-40-9898 Yrs Nov. 25, 1927 79 Director Georgia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits i Hygiene. other then "natural", or items 23a or 28a-f ehow vent, the Musical Examiner must be notified at 1X Yes 2 No Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3320 Benson Avenue 21227 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours atter c Department of Health and Mental Hygiene. Important: if Item 27 ie marked other then "natural", or Item any injury or other treumatic event. Ite Medical Expenses 1 ☐ Yes 2 ☑ No ff Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Garnto ၉ Ella Mae Parrish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance B. Gilder, SSJ-Daughter 308 Stratford Road; Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State Metro Crematory 4/10/2007 Catonsville, Maryland 4 □Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. uneral Service 21. Signatur 0/290 1630 Edmondson Avenue; Catonsville MD 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ementia envs **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Pol in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part f. ģ elisorder 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No Chronic Dann 1 Yes 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physician: "within 24 hours after death." To the Funeral Director: After this certifica 25. Was case referred to me licat examiner? 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 1000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Lenson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 1 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. C. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month FREDERICK 08 1007 03:30 AM 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Baltimore Rehabilitation Extended Baltimore City Baltimore 8. Date of Birth (Month, Day, Year July 2 1925 Birthplace (State or Foreign Country) Social Security Number Months 1 M 2 □ F Davs Hours Min. 212 22 9511 Baltimore, Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 □ No Maryland Baltimore City Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5417 Creston Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1, TYes 2 □ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 □ No 1 ☐ Yes 2 🛣 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Routeman Lord Baltimore Cleaners 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Nelson Baker Mabel Regina Jaeger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth T Baker 5417 Creston Avenue Baltimore, Md. 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Parkwood Cemetery April 12 2007 Baltimore, Maryland 21. Signature of Funeral Service/Dicensee 22. Name and Address of Facility 7401 Belair Road ather Lassahn Funeral Home Inc. Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiac Due lo (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No 27. Manner of Death Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 Tyes 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

be executed burial-transi Box 68760, attending physician for use as the buria P.0. signed by the a d be detached f Records, page 2 s has certificate Division or Vital

Exami Physician/Medical Completed Be ည in by the funeral e Hospital or Attending P 124 hours after death. e Funeral Director: After t Certification: After within 24 hours a completely filled

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

Funeral

Be

7 Is marked other than "natural", or Items 23a or traumatic event, the Me Ital Examiner must be it

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Me

Physician

/Medical

Examiner

72 hours after

Baltimore, Maryland 21215-0036

To the

State Registrar

Medical

4 Homicide

29b. Signature and title of certifier

29a. Certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

ause of death (Item 23a) (Type, Prin

and manner stated.

an filed (Month, Day, Year) APR 1 1 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Ам Mary Jane Brooks-Richardson /Medical 4b. City, Town, or Location of Death 4c. County of Death . Facility Name (If not institution, give street and number) Examiner Baltimore osedale 8. Date of Birth (Month, Day, Year)
Tune 2, 1917 If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Age (In yrs. last birthday, **Funeral** Days 1 □ M 2 □ 238-34-6582 89 NC Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits fshow 10a. State 10b. County "natural", or items 23a or 28a-f showder al Examiner must be notified at Baltimore 1 ☐ Yes 2 X No Director Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 19 Harrison Avenue USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married \mathcal{B}_{Rbb} אנגי איזאיא Baltimore, Maryland 21215-0036 1 ☐ Yes ≱☐ No Specify Specify: White ò 3 Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Bowers Charity Taylor 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4127 Beachwood Road Baltimore MD 21222 Ronnie Richardson /son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1√ Burial 2 Cremation 3 Removal from State 4 Denation 5 Other (Specify) 4/12/07 Belair Memorial Belair MD 22. Name and Address of Facility 21. Signature of F eral Service Licenses 300 Mace Ave.Balto. 21221 Connelly Funeral Home of Essex Approximate Interval Between Onset and Death ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, buse on each line. 23a. Part 1. Enter the disease, o co shock, or heart failure. List on Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine be executed burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria P.O. Box 68760 Physician/Medical certificate IF FEMALE 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was a autopsy performed? Ves 2 No certificate 1□ Yes Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 3□ D0A ပ္ 1 ☐ Yes 2 ER/Outpatient 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? Certification: 27. Magner of Death (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified WID RES 000 08,2007 MPRIL 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 9000 Drive, Baltimore, MD 21237 Khim Franklin Lay Square 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

		For State Registrar	State of Ma	aryland	-	artment of F rtificate of		ind Mental	Hygie Reg.	()	07	11374
Physic		1. Decedent's Name (First, Middle, La Joseph William						2. Date Apr	of Death	2007	Year	3. Time of Death 11:48 AM
/Medi Examii		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, o	or Location of	f Death		4c. County	y of Death	
		Gilchrist Cente	er			Towson				Bal	timor	e
Funeral Director			Sex 7. Age 7. A		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date (Mor.	of Birth hth, Day Ye 2 15 19	31	9. Birthp Cour Balti	lace (State or Foreign htry) More, Maryland
pur w		Usual Residence of Decedent 10a. State 10b. County		10c, City	, Town or Lo	cation			-		1	0d. Inside City Limits
faryla shor	ō	Maryland Baltimore			imore C							1 □Yes 2 □ No
the N 28a-1 notifi	rect	10e. Street and Number		Dane	Dioze e	10f. Zip Code			10g.	. Citizen of	What Cour	ntry?
with	٥	8820 Walther Blvd. A	pt 3610			21234				USA		
should be filed within 72 hours after death with the Maryland should be filed within 72 hours after death with the Maryland ind Mental Hyglene. I marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	Funeral Director	11, Marital Status	12. Was Decedent I	Ever in U.S	3. 13.		lispanic Ong	in? (Specify Yes	or No-		ce - Americ	
or Ite		1 ☐ Never Married 2 ☐ Married	Armed Forces?	No				, Puerto Hican, e	(C.)		ck, White,	etc.
ral", c	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	WII		1 □ Yes 2 ☑ No	эреспу.			Specia	w. Wh	ite
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led w lygien her ti		17. Father's Name (First, Middle, Last	N/A		Servic	e Manager/S		⊇ ρ. r's Name <i>(First, I</i> I		erator		
ntal Hed ot	Be	Joseph William Bass						ret Helen	•	our curriu	,,,,,	
d Me	၉	19a. Informant's Name/Relationship			19b Mailii	ng Address (Street	1			City or Town	. State. Zir	Code)
d 2 s th an th an traul		Gladys A Bass	1,400.7 1111.0			Walther Bly				•		*
ie; wall y failed within 72 hours after death with the Marylan if Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition		20b. Pl		osition (Name of matory or other pla		Date		c. Location		
Pages 1 and of He		1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		- 1		ntory Inc		10 2007	Ba	altimor	e.Marv	land
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\$ T		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death	. Do not en	ter the mode of dyi	ing, such as	cardiac or respira	itory arrest	t,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition			NA	(m	CER					Onset and Death
/Medical		resulting in death)	Due to (or as	a consequ	ence of							,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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be e) ician buria	a E	l l										
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	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Da	ate of deliv	ery
death death defor	icia	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant at			□Ectopic pregnand □ Other <i>(specify)</i> _	СУ			М	lonth	Day Year
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gned be dei	by P	Part II. Other significant conditions	contributing to death b	ut not resu	ılting in the u	nderlying cause gi	ven in Part I.	236				he cause of death?
equire equire ould t									1 Yes	2□ No	3 ☐ Proi	bably 4 ∐Unknown
law r as be	Completed							248	. Was an autopsy		prior to co	opsy findings available impletion of cause of
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Physical this call dire	မ	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatie		ER/Outpatie	III S DOA		rsing Home 5		ce 6 do	<u>. </u>	(v) Hospice
ding l	ion	Matural 5 ☐ Pending	(Month, Da		Injury	Wo	ork?]Yes 2∐1		scribe now	injury occu	irred	,
Attending Physician: r death. ector: After this certification by the funeral director, I	ertification:	3 Suicide 6 Could not b	e 28e. Place of inj	ury - At ho	me, farm, st	reet, factory, office		28f. Loc			ber or Run	al Route Number,
affer din by	ertii	4 ☐ Homicide determined	building, et	c. (Specify	1)				or Town,			-,
E Hospital or Attending Physician: 24 hours after death. E Funeral Director: After this certific letely filled in by the funeral director,	O	29a. Certifier 1 Certifying P	hysician: To the best	of my kno	wledge, dea	th occurred at the t	time, date an	d place, and due	to the cau	se(s) and n	nanner as	stated.
e Ho 1 24 h e Fu letely	dical	(Check only 2 ☐ Medical Exa one)	miner: On the basis of and manner st		tion and/or it	nvestigation, in my	opinion, dea	un occurred at the	e time, date	e and place	, and due f	o tne cause(s)

Registrar

State

		1	For State Registrar	State of N	1aryland		artment of H		nd Mer		ene	07	113	75
			Decedent's Name (First, Middle, I	.ast)						Date of Death Month	Day	Year	3. Time of De	ath
	Physicia /Medic		Mary Jane Brehm							April 10	1		7:35 A	М
	Examin	er	4a. Facility Name (If not institution, g	ive street and numbe	r)		4b. City, Town, or	r Location of	Death		4c. County	y of Death		
px 13	The Art	9.	Marley Neck Healt 5. Social Security Number 6	h And Rehab	Age (In yrs. las	t hirthday)	Glen Bur If Under 1 Year	nie If Under 2	4 Hrs. g	Date of Birth		Arunde	lace (State or F	oreian
	Funeral Director		218.26.9661	1 M 2 DF	76	Yrs.	Months Days	Hours	Min.	(Month, Day, uly 1, 1	Year) 930	Cou	ntry) MD	
	Qr.	-	Usual Residence of Decedent									-		
	how		10a. State 10b. County		10c. City, 1	Town or Lo	cation						10d. Inside City	
	S -4 s	ctor	MD Anne Aru	ndel	Hanove	er							1 🗌 Yes 2	-XX
	or 28	Dire	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Cou	ntry?	
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	Jwithn 72 hours after death with the maryland jiene. rthan "natural", or Iteme 23a or 28a-f ahow the Medical Examinat noust be notified at	Funeral Director	11. Marital Status	12. Was Deceder	s?		Was Decedent of H If Yes, specify Cuba	an, Mexican,	Puerto Rica	an, etc.)		ck, White,		
36	urs all	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, GiveX Year or Date:	X		1□Yes 2□XX	Specify:			Specia	<i>⁄y:</i> ₩h i	te	
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215	within / ene. than "n	ple	(Specify only highest Elementary/Secondary (0-12)	College (1-40	or 5+)	lite.	DO NOT use retired	d)	or working					
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pu	G 12 5	Be	17. Father's Name (First, Middle, La	st)				18. Mother	rs Name (F	irst, Middle, N	iaiden Sumai	me)		
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Mar	th and the and		19a. Informant's Name/Relationship	(Type, Print)							City of TOM	i, State, 21	0 0000)	
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9 ×	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE:	23c. If yes, outcor	ne of pregnanc	су					23d. D	ate of deliv	rery	
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o.	it the de by the tached	ysie	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow										
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~	iding Phyeicien: th. : After this certifica s funeral director, p	10 E	1 Yes 22 No	Hospital: 1 🗆 Inp	atient 2□El	R/Outpatie	INT 3 DOA		rsing Home	5 🗆 Reside	ence 6 🗆 O	ther (Spec	ify)	
	ng Pl		27. Manner of Death Natural 5 Pending	28a. Date of I (Month,	njury 2 Da <i>y Year)</i> 2	8b. Time Injury	Wo			d. Describe ho	w injury occu	urred		
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Ξ	l or At after of Direct	E	4 Homicide determin	28e. Place of	etc. (Specify)	ne, tarm, s	treet, factory, office		201	City or Town		noer or nu	rar rioul o reumb	<i>31</i> ,
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier Certifying	Physician: To the b	est of my knowl	ledge dea	th occurred at the fi	me, date an	d place, and	d due to the o	ause(s) and n	nanner as	stated.	
	To the Hospital within 24 hours and the Funerel Completely filled	edical	(Check only 2 Medical E	xaminer: On the basi and manner	s of examination	on and/or i	nvestigation, in my	opinion, deal	th occurred	at the time, d	ate and place	e, and due	to the cause(s)	
	omple	₹	29b. Signature and title of certifier	-			29c. Licen	se number		2	9d. Date sign	ned (Month	, Day, Year)	
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	1.		30 Name and address of derson w	no completed cause	of death (Ver)	23a) (Type	, Print	11 00		_	1 1 1	n	71823	
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State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Year M. 5:20P^M BRATCHER APRIL 9, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON

1 Year If Under 24 Hrs.

Min. GILCHRIST CENTER FOR HOSPICE CARE BALTIMORE If Under 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F Months Yrs. 246-12-9224 84 **Director** 9-6-1922 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3902 WOODBINE AVENUE 21207 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: 3 Widowed 4 Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HOMES 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 DOC STROUD CATHERINE DOUGLAS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KENNETH BRATCHER, SR./SON 3902 WOODBINE AVE. BALTIMORE, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEM PARK 4/14/07 BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee JAMES A. MORTON & SONS F.H., INC. Q tton 1701-31 LAURENS ST. BALTIMORE , MD 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death lebilit Immediate Cause (Final disease or condition resulting in death) **Physician** YENS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate any leading to immediate and leading to immediate and leading to immediate and leading that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending | for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2DNo this certificate 1∐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPI (Hospital: 1 ☐ Yes 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 ☐ Homicide within 24 hours a To the Funeral I propertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely (Check only and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 78 NSON MD 21204 CHARCES cmo hories Sr 6701 31. Date filed (Month, Day, Year) 2. Registrar's Signature State APR 1 1 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** BOOTH 7:45 P M 7RTHUR APRIL 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner BALTIMORE RANDALLSTOWN COURT OLD FUTURE CARE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. 03-07-198 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) P. HSburgh PA Funeral Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
and: if item 27 is marked other than "naturat", or items 23a or 28a-f show and the there is no the than "naturat", or items must be notified any or other traumatic event, it in Marical Example. 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Transit Authorit Elementary/Secondary (0-12) Coilege (1-4or 5+) Zurs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health ar Important: If item 27 is any injury or other trau once. MD21133 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 Burial 2 □ Cremation Date 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as eardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Gunknown FAILURE RENAL Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b autopsy performed' 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 NO Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ို s after death.

I Director: After this c 28d. Describe how injury occurred 28a. Date of Injury (Month, Day) 27. Manner of Death Certification: Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of entiries 057722 APRIL M-D. n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TREE ROAD \$300 PILLESVILLE MD 21208 M.D. 1838 GREENE RICHARPSON LEONARD

State

Registrar

31. Date filed (Month, Day, Year)

2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Brown Steven 2007 5:05 AM 0 HDYI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore University of Mary land Hedical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 219-84-9052 Director 06/20/1962 MD Usual Residence of Decedent the Maryland 10a. State a or 28a-f show t be notified at 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 XYes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 607 Glenolden Avenue 21216 "natural", or items 23a dical Examiner must t permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event the Madi USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced American 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) laborer roofer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Curtis E. Brown Geraldine Knox ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Brown / Mother 607 Glenolden Avenue; Baltimore, Maryland 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 04/16/2007 Baltimore, Maryland 21. Signature of Funeral Service Licenser 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 North Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): End Stage Renul Diseuse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury pue to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 4 Unknown 1 Yes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe After this certificate 1□ Yes 2IX No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital 🛮 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number

Registrar DHMH 17 Rev 1/2001

State

Bulhmore MD 2120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nayal

APR 1 1 2007

31. Date filed (Month, Day, Year)

22 S Greene St

. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician if M BERAN 2007 AMES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5. Social Security Number 8. Date of Birth Month Day, May 21, 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 63 Yrs. 212-42-5267 Director Maryland Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits Show Examiner must be notified at Delaware 1 □ Yes 2 No Director Sussex Rehobeth Beach or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Tiffany Drive "natural", or items 23a 19971 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ZYes 2 No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mertal Hygiene. and it item 27 is marked other than "natural", or iten any or other traumatte event, the Medical Examineary or other traumatte event, the Medical Examineary. 1 Never Married 2 Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify: þ Specify. White 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Roller Bethlehem Steel 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Beran Mary Theresa Weir 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Marie Beran Tiffany Drive Rehobeth Beach, DE 19971 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of h important: If ite any Injury or of XXBurial 2 ☐ Cremation 3 ☐ Removal from State Oaklawn Cemetery 4 Donation 5 Dother (Specify) April 14,2007 Baltimore, Maryland 22 Name and Address of Facility Charles S. Zeiler & Son, Inc. 6224 Eastern Avenue Baltimore, 21. Signature At Funeral Service Licensee 2da. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** L'DULL MOINE Due to or as a consequence of): disease or condition resulting in death) minutel /Medical Examiner CONCINA Sequentially list conditions, francial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dia to (or as a consequence of) Examine The law requires that the death certificate be executed inding physician and use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical signed by the attending I IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.
To the Funeral Director; After this certificate has I completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2. autopsy performed? Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ို 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 Natural (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🚅 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) les-000

State Registrar

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Hospital 600 N. Coolfe St Bettimore, MD

The Johns Hapking

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2<u>007</u> Month **Physician** <u>12</u>:50 P[™] ERNEST O'FARRELL BYRD, JR. April /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BROADMEAD <u>Cockeysville</u> Baltimore County Birthplace (State or Foreign Country) Hrs. 8. Date of Birth Min. (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year) **Funeral** Days Months 1**∑**M 2□F Yrs. 1915 16, West Virginia Director 233-14-7398 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location show or Items 23e or 28a-f shov 1 ☐ Yes 2 X No Director Maryland Baltimore County Cockeys<u>ville</u> Byrch, Ernest 10g. Citizen of What Country? 10f. Zip Code 13801 York Road, 21030 USA Funerai Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 X Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: er then "naturel", or Specify: White by 3 ☐ Widowed 4 ☐ Divorced ieted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Compi . Pages 1 and 2 should be filed within tment of Health and Mental Hygiene. tent: If item 27 le marked other then ' College (1-4or 5+) Elementary/Secondary (0-12) Exxon Oil Company 4 yrs Auditor/Cashier 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ernest O'Farrell Byrd, Sr. Blanche Davenport 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Gertrude Troph Byrd (Wife) 13801 York Road, B-4, Cockeysville, Maryland 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 4/9/2007 Baltimore, Maryland 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC.
Maryland 21212 21. Signature of Funeral Service Disease

Martin D. Lawson 6500 York Road, Baltimore, Maryland Approximate Interval Between Onset and Death, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last requires that the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year should be detached for in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 **N**o 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 212 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place o Death Check on one Be 25. Was case referred to medical examiner? Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 INo 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death **Physician** De are -2007 /Medical institution, give street and number) Town, or Location of Dea unty of Death Examiner House +tospice astmins arro If Under 24 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Min 216-30-0865 1 M 2 F Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. CH Town or Location 10d. Inside City Limits r 28a-f shov notified at 1 □Yes 2 No tonsu **Funeral Director** ALD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and r than "natural", or items 23a or the Medical Examiner must be r Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0036 Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ost of working (Give kind of work done durin life. OO NOT use retired) al Hygiene. other than " ege (1-4or 5+) Elementary/Secondary (0-12) of Health and Mental Hygie Hear 27 is marked other to r other traumatic event, the 7. Rather's Name (First, Middle, Last, Be brown Department of Heal Important: If Item 2 any injury or other Baltimore. 20b. Place of Disposition (Name of cemittery, crematory or other od of Disposition 20c. Location 1 Burial 2 4 □ Domation 2 Cremation 3 Removal from State 5 ☐ Other (Specify) re of Fun-ra Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresponds, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) BREAST C **Physician** 4 MONTHS /Medical BREAST CAPUC Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1☐Yes 2☐00
9☐Unknown Day Year 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 Physician: 25. Was case referred to medical examiner?

1 Yes 2 You Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) FICSPICE 3□ DOA ۵ 1 🔲 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Divatural 5 Pending investigation after death.

I Director: A
d in by the fu 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number of death (Item 23a) (Type, Print) OHNS MOPKINS WOLFF. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene; Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 30 AM 200 OUIC /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 20sedale mare If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign 1 M 2 F Months Days Hours 3 Director 219-30-089 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 15 22 12. Was Decedent Ever in 11.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗗 If Yes, Give Year or Dates: 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Be Completed by Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DLDN 2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NKNOWL ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 61 Baltimore, 200. Place of Disposition (Name of cemetery, grematory or other 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Thomas 23a. Part1. Enter the disease, w com shock, or heart failure. List only complications that caused the death. only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical a a consequence it: **Examiner** Q V Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed as the burial-trai Due to (or as a consequence of) the attending physician Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after death e Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 elli 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 000 Khin, MD RES April 05, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN SQUARE DRIVE, BARTIMORE, MD21237 KHIN LAY 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

CLARIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** 6:30AM MORIL 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sec ours ttospital orl If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**☑**M 2□ F Months Days Hours 217-84-8404 Director CC. 2, 1 mara Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location a or 28a-f show t be notified at 10a. State 10b. County 10d. Inside City Limits 1 →Yes 2 No Director Timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a -agette 22 Funeral 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☐ Mo Blan ò Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) over soll 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) orbett larence 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Deportment of Health a Important: If item 27 is any injury or other trainonc. -mother 1020 E. 3 3rd Emma Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 □ Surial 2 □ Gremation 3 □ Removal from State Cem. 4 □ Donation / 5 □ Other (Specify) Lon 23a. Part Enter In sease, or complications that caused the death. Do not enter the most of dying, such as cardiac or respiratory arrest, immediat Carles (Final disease of or indition resulting in death)

23a. Part Enter In sease, or complications that caused the death. Do not enter the most of dying, such as cardiac or respiratory arrest, immediat Carles (Final disease of or indition resulting in death) 21. Signature of Juneral Service License 22. Name and Address of Facility FredHILT Funeral Home Baeto, md, 21229 Approximate interval Between Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for es a consequence of Physician/Medical Examiner The law requires that the death certificate be executed physician a the burial-P.O. Box 68760. as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 2. No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 N 3□ DOA 2 ☐ ER/Outpatient 27. Man of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) Injury 1 atural 5 ☐ Pending 2 Accident investigation 1 Yes 2 No Director: / 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours To the Funeral 29a. Certifier wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)_

State Registrar

31. Date filed (Month, Day, Year)

APR 1 1 2007

32. Registrar's Signature

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 April 10, **Physician** 3:25 AM Edith Louise Daniel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Catonsville Renaissance Gardens If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) Aug. 12, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 4 F 93 1913 Director 215-80-9832 Aug. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notifiled at Catonsville 1 ☐Yes 21K No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 709 Maiden Choice Lane RGS430 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise Schroeder William Benjamin Martin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard W. Daniel 1302 Roundhill Road; Baltimore, MD 21218 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Good Shepherd Cemetery 4/12/2007 Ellicott City, MD 5 Other (Specify) 4 □ Donation 22. Name and Address of FacilitySterling Ashton Schwab Witzke 21. Signature of Funeral Service Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, 01290 MD 21228 23a. Part1. Enter the Asi, ase, or complications that caused the death, shock, or heart in ilure. List only one cause on each line. Immediate Cause ("Inal dispersion cause") Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Neumonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Exist Unity in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No has autopsy performed? this certificate or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

within 24 hours a To the Funeral I

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certified

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

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32. Registrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year!

2007

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Choice

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician April 2007 Vincent Domzalski 9:10 A. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 6732 5th Avenue Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 5, 1917 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours **X**□M 2□F 215-05-5142 90 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 XNo Director Md. Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 USA 6732 5th Avenue Funeral 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2√☐ No Specify þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 th College (1-4or 5+) Continental Can Factory Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Genewefa Catka Stefan Domzalski ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Diana Chavis/step-daughter 6732 5th Ave. Baltimore, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4-12-07 Holy Rosary Cem. |Baltimore,Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilikaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Ave. Baltimore, Md. 21222 rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pros Physician years disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ned by the atter detached for u in the past 12 months? Month Day Year 5 Other (specify) 1 □ Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 1□ Yes 2**X** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home SYNesidence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ◯XNo Certification: To this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury After (Month, Day Year) Injury 1X Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 ☐ Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed safter death. To the Hospital within 24 hours a To the Funeral I

completely State

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

David

29a, Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Silver, D.O. 3509 Eastern Ave. Baltimore, Maryland 21224 32. Registrar's Signature

(Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

H 43234

29d. Date signed (Month, Day, Year)

April 9, 2007

Registrar

State of Maryland / Department of Health and Mental Hygiene

		•	for State Registrar		,	Cei	rtificate of	Death			Reg. No	200	1 11301
F	Physicia	3	1. Decedent's Name (First, Middle							2. Date of De	eath Da	ıv Year	3. Time of Death
	/Medic	_	Rosalie J. Din							April	9, 2	2007	9:09 AM
	Examin	er	4a. Facility Name (If not institutio	-)		4b. City, Town,		of Death		40	County of De	
		447	Franklin Squar 5. Social Security Number		no /In ure	last birthday)	Roseda		24 Hrs.	8 Date of Bi	rth	Baltimo	nthplace (State or Foreign
l	Funeral Director		212–30–7927 Usual Residence of Decedent	1 M 2 F	9:		Months Days		Min.	8. Date of Bi (Month, Di April	12,	1913 N	Sountry) Saryland
	land ow		10a. State 10b. County	,	10c. City	y, Town or Lo	cation						10d. Inside City Limits
	Mary Fied	to	Maryland N/A		Bal	ltimor	e						1 □Yes 2 No
	h the or 28a o noti	Funeral Director	10e. Street and Number				10f. Zip Code				10g. Ci	tizen of What C	country?
	th wit 23a c 1st be	alD	4313 Belmar Av	enue			2120	6			U	S.A.	
	r dea	laur	11. Marital Status	12. Was Decedent Armed Forces ried 1 ☐ Yes 2	Ever in U.	S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Ori can, Mexica	igin? (Spe n, Puerto	ecify Yes or N Rican, etc.)	D-	 Race - Am Black, Wh 	
220	s. 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 □ Never Married 2 □ Mar 3 🔀 Widowed 4 □ Divorced				1□Yes 2□No	Specify:	:			Specify: W	hite
5	72 ho natur lical I	Completed	15. Deceder	nt's Education est grade completed)		16a. Dece	dent's Usual Occu	pation	st of worki	na	16b. k	(ind of Busines	s/Industry
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7	led w lygier her th	ဒ	6th Grade	n/a		Ho	<u>usewife</u>	19 Moth	or'o Namo	(First, Middle	_	ler own	home
2	lbe fi	Be	17. Father's Name (First, Middle,	, Last)								ŕ	
Ž	hould d Me mark matic	2 L	August Thieme 19a. Informant's Name/Relations	ship (Type Print)		19b Mailir	ng Address (Stree					chmidt	Zin Code)
2	nd 2 s Ith an 27 is trau		Mrs. Carolyn B				Belmar A						
ַם ע	f Heal		20a. Method of Disposition		20b. P	Place of Dispo	sition (Name of matory or other pla	avenue		ate		ocation - City o	
2	Page ent o nt: If i		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Memorial	100)	4/13	/07	Ве	1 Air,	Maryland
Dallinior	permit. Pages 1 and Department of Heall Important: If item 2 any injury or other once.		21. Signature of Funeral Service	Kigensee		22	2. Name and Addr	ess of Facili	ity	T II		T	
۵	Per La		1 Asmile				Miller-1 6415 Be	lair F	Road	Ralti	ome, more	, MD 2	1206
			23a. Part1. Enter the disease, o shoet, or heart failure. Lis	r complications that cause t only one cause on each	d the death line.	h. Do not ent	er the mode of dy	ing, such as	s cardiac o	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a Myou	ardi	al int	faretion						Onset and Death
	/Medical Examiner		resulting in death)										, mm ediate
	<i>*</i>	Į.	Sequentially list conditions,	b. Due to (or a	perto	en9107 uence of):)						
	nted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<									
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0	ertifica ing ph e as th	Med	IF FEMALE:										1
õ	ath ce	ian/	23b. Was decedent pregnant in the past 12 menths?	23c. If yes, outcom 1 ☐ Live birth	2 🗆 Feta	I death 3	Ectopic pregnanc	су				23d. Date of d Month	elivery Day Year
5	the de	Physician/	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of d	eath 5L	Other (specify) _						
ŗ.	sician: The law requires that the death ce certificate has been signed by the attendi rector, page 2 should be detached for use		Part II. Other significant condit	ions contributing to death	but not resu	ulting in the u	nderlying cause gi	iven in Part I	I.	23e. Did	tobacco	use contribute	to the cause of death?
ecords	luires sign ld be	d by	•							1 🗆	Yes 2	2 12 No 3□I	Probably 4 Unknown
5	w rec	lete								24a. Was	an .	24b. Were	autopsy findings available completion of cause of
	The Is te has age 2	Completed									ormed	I death'	completion of cause of es 2 □ No
VILA	lan: rtifica xtor, p	o	25. Was case referred to medica	al				26. Place	e of Death	(Check only		0 1010	
	nysic nis ce direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpat	ient 2 🔯	ER/Outpatier	nt 3□ DOA Ot	her: 4 🗆 Ni	ursing Ho	me 5□Res	idence	6 □Other (Sp	ecify)
5	ng Pl		27. Manuer of Death 1 ☑ Natural 5 ☑ Pendi	28a. Date of Inj (Month, D	ury a <i>y Ye</i> a <i>r)</i>	28b. Time o Injury	Wo			28d. Describe	how inju	ury occurred	
VISIOII	Attending Physician: r death. ector: After this certific: by the funeral director, i	cati	2 Accident Invest	lgation at he				Yes 2		201	/=-		
2	al or At after d I Direc d in by	Certification:	4 Homicide determ	nined Zoe. Flace of II	ijury - At no etc. <i>(Sp</i> ecif	y)	eet, factory, office	•		City or To	(Street a wn, Stai	nd Number or I te)	Rural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	- a	(Check only 2 84 adios	ng Physician: To the bes I Examiner: On the basis and manner s	of avamina	tion and/or in	vestigation in my	oninion de	ath occur	and at the time	dato ar	h bac and d	up to the cause(s)
	o the	Mec	29b. Signature and title of certific	er_	nateu.		29c. Licen	ise number			29d. Da	ate signed (Mo.	nth, Day, Year)
)	1		15				200	n621	ر کے		41	10107	
	5		30. Name and address of persor	n who completed cause of	death (Iten	n 23a) (Type,	Print)	-270	00			10/07	
	0		Sunas Ma	dyram	201	Pall	ard Cev	c, Z	Balti	more	M	0,21	220
	Sta	ite	30. Name and address of person Suhas 31. Date filed (Month, Day, Year	32 megis	trar's Signa	ature						-	
	Registi	rar	AFRI.	L ZUUT JORGE	se d	K A	ach i						
	MH 17 Rev 1/2	001				A STATE OF THE STA							

Audrey Eaton		State of Maryland / Department of I-For State Certificate of Cert		ygiene Reg.	No. 2007	14388
Physiciai Mędical Examin		1. Decedent's Name (First, Middle, Last) Audrey Eaton		2. Date of Death Month D April 5, 2007	ay Year	3. Time of Death 1420 hrs
		Facility Name (if not institution, give street and number) Northwest Hospital Center	4b. City, Town, or Location of Death Randallstown	1	4c. County of Death Baltimore Cour	ntv
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs		MM/DD/YYYY) 9. Birth Foreign	nplace (State or
Director	į	2/2 · 6 0 · 5 5 9 3 1 □ M 2 ▼ F 55 Y Usual Residence of Decedent	rs. Months Days Hours Min	12 6	195) cou	ntry) MD
w any	Ì	10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits
Maryland 28a-f show d at once.	ţċ	10e. Street and Number	101, Zip Code	10a.	Citizen of What Count	1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once	D Fe	21038 Fast Horrman Street	21213		USA	
eath with items 2 ust be n	Funeral Director	1 Never Married 2 Married Armed Forces?	Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,
s after d	ð. F	or Dates:	Yes 2 No specify:		Specify: Bic	ach
72 hours	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	ent's Usual Occupation (Give kind of most of working life, DO NOT use reti		6b. Kind of Business/In	idustry
5-0036 Led within Hygiene Lother tha the Medic	Completed	17. Father's Name (First, Middle, Last)	Hearth Speci	alist First, Middle, Mai	ederal G	au -
ID 21215-0036 should be filed within 7 and Mental Hygiene 7 is marked other than antic event, the Medic	å	Plummer Owen Eaton	Mary	Machs	,	· · · · · · · · · · · · · · · · · · ·
MD 2' d 2 should Ith and Mt n 27 is m;	ှိ	19a. Informant's Name/Relationship (Type, Print) 19b. Maili 19b. Maili 19b. Maili 19b. Maili	ing Address (Street and Number or I			Zip Code)
- E E E E	İ		osition (Name of cemetery,	Date 2	Oc. Location - City or T	Town, State
Baltimore, permit. Pages I at Department of He Important: If ite injury or other tr	-	4 Donation 5 Other Specify:	Name and Address of Facility VO	13.2007	Pihroville	MD Stroice
		Vaudin C. Green 8	728 Liberty M	d Monde	all sieur M	nD 31133
Physician /Madical		23a. Part I. ♣ Inter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Immediate Cause (Final disease a Asphyxia due to airway obstruction)		or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. ASPNYXIA due to alrway obstruction but to condition resulting in death) Due to (or as a consequence of):	on by 1000 bolds			
	ner	Sequentially list conditions, if any, leading to immediate cause. Ernei Uniderlying Cause				
¥ 5 5	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
60, c be executed ysician and burial - transit	ledical E	d. UNPENDED AMENDED				
3760, finate be exerging g physician s the burial		IF FEMALE: 23b. Was decedent pregnant in the control 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregna		23d. Date of delivery Month D	ay Year
Box 6876 e death certificate the attending phy ed for use as the I	Physician/N	past 12 months?	Other (Specify)			
O. B. nat the de de de de de de de de de de de de de		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		cco use contribute to t	
cords, P.O. B law requires that the d has been signed by the should be detached 2 should be detached	ted b	Atherosclerotic cardiovascular disease		1 Yes		opsy findings available
Division of Vital Records, P.O. ral or Attending Physician: The law requires that th rs after death. "al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	Completed by			autopsy performe 1 ✓ Yes 2	ed? death?	ompletion of cause of
tal Recian: The certificate ector, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ FR/Outpatie	26.Place of Death (Check			
of Vi ing Physi After this	의	1 V Yes 2 No 28a. Date of Injury 28b. Time of		ng Home 5 Re 28d Describe how Subject chock		
Sion Attendir death. sctor: A	cation	1 Natural 5 Pending Investigation 2 Accident	1 ✓ Yes 2 No		eet and Number or Rur	ral Route Number City
Divis	Certification:	Suicide Could not be determined (Specify) lunch room	reet, factory, office building, etc.	or Town, Stat 4500 Security B	te) oulevard, woodlawn	, MD
Fu H	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurrence) 2 Medical Examiner: On the basis of examination and/or investig	curred at the time, date and place, and gation, in my opinion, death occurred	d due to the cause(s at the time, date an	s) and manner as state d place, and due to the	ed e cause(s)
To the within To the comple	Med	29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Mon	
Ch Ch		20 News and address of access who completed course of death (Horn 22a)	O.C.M.E.		April 6, 2007	
5		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Str	eet, Baltimore, MD 21201			
Sta Regist	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	R. 0			

		1	For State Registrar	'lease	State of		yland / D	epa	ırtmen	nt of H		and N	II Copie Iental H		ne2 ()	0 7	11389
Phy	sician		. Decedent's Name (First,			<i>.</i>							2. Date of D	eath [Day	Year	3. Time of Death
	edical		Carl Cal						4h City	Town o	or Location		April		2007 4c. County	of Death	2:35 A. M
Exa	miner		10 Hillvi								svill					ltim	
Fune	ral	5	. Social Security Number	6. S	өх	7. Age (II	n yrs. last birti	hday)	-	r 1 Year		r 24 Hrs. Min.	8. Date of 8	irth			place (State or Foreign intry)
Direc		_	198-14-8348 Usual Residence of Deced		Ø M 2□F		81	rs.	Months	Days	Hours	IVIIII.	July	29,	1925	Pen	nsylvania
/land		-	Oa. State 10b. C		24	10	Oc. City, Town	or Lo	cation								10d. Inside City Limits
Man	ţ		Maryland Bal	timor	e		Cato	nsv	ille								1 ☐ Yes 2 No
or 28	Director		0e. Street and Number						10f. Zip	Code				10g.	Citizen of \	What Cou	intry?
ath w	- R		10 Hillview	Drive				,		228					JSA_		
er de	Funeral	1	1. Marital Status	7 Marada d	12. Was Dec		r in U.S.	13. V	Vas Dece Yes, spe	dent of H cify Cuba	lispanic Or an, Mexica	rigin? (Sp in, Puerto	ecify Yes or N Rican, etc.)	10-		e - Amer ck, White	ican Indian, , etc.
11215-0036 within 72 hours after death with the Maryland ene.	d by F		1 ☐ Never Married 2 ☐ 3 🛣 Widowed 4 ☐ Div		If Yes, G Year or I	2 No ive Dates:		1	□Yes	2 ⊠ No	Specify				Specify	v: W	hite
215-(plete				de completed,) (1-4or 5+)	16a.	Deced (Give : life. [ent's Usu kind of wo DO NOT u	al Occup ork done se retire	ation during mod d)	st of work	in g	16b.	Kind of B	usiness/l	ndustry
d 21, filled with Hygiene	Į		Liamonaly Coccidary (, 12,	5+	(1-401 5+)	E1	ect	rica	1 En	ginee	er		V	Vesti	ngho	use
Baltimore, Maryland 21215-0036 sermit. Pages 1 and 2 should be filled within 72 hours alt Department of Health and Mental Hygiene. If them 77 is marked other then "neture", or movinture of the stream of the marked other them."	To Be Completed	1	7. Father's Name (First, M Robert Fran										e (First, Midda einer	le, Maid	len Suman	7e)	
aryla 2 should I and Men is marke	ļ		19a. Informant's Name/Re	ationship (Type, Print)		19b.	Mailin	g Address	s (Street	and Numb	er or Rur	ai Route Num	ber, Cit	y or Town,	State, Z	p Code)
and and a			Pamela K. Fr	anken	field-						n Cou						
Pages 1		2	t0a. Method of Disposition 1 → Burial 2 ☐ Crem 4 ☐ Donation 1 5 ☐ Ot			State	20b. Place of cemeters Lake V	Dispos , crem iew	natory or o Mem	me of other place • Pa	rk 4		Date 2007			-	own, State Maryland
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene, important of Health and Mental Hygiene, important if them 271 marked of other then "netural, or items 238 or 288-1 ehow any interest."	DUC	1	21. Signature of Fineral S	-			20	22	Name ar Fune:	nd Addre	ss of Facil Home	Ster of C	ling A atonsv	shte	on Sc	hwab c.	Witzke
			23a. Part1. Enter the disea	ise, or com	plications that	eaused the	e death. Do n	ot ente					renue; or respiratory		onsvi	He.	Approximate
Physici /Medic	_		shock, or heart failure Immediate Cause (Final disease or condition resulting in dealh)	. Listonly	Como	xette	me h	سمع	ب	fai	lur	٥					Interval Between Onset and Death
Examir				- 1	Val	Jula	onsequence of	۱۱): اعسو <u>ص</u>	J	de	Sea	J					
D :	je		Sequentially list conditions fany, leading to immediat cause. Enter Underlying Cause (Disease or injury	₹	Due to	(or as a co	onsequence o	f):									
Box 68760, sath certificate be executed attending physicien and for use as the burial-transit	Examiner	4	hat initiated events esulting in death) Last	1	c	(or as a co	onsequence o	f):							_		
8760, ate be ex hysicien at the burgal				•	d	-											
Box 68 sath certificat attending phy	Me.		F FEMALE:		220 16 1100 01	utaama af n										11_	
Vision of Vital Records, P.O. Box 68760, Attending Physicien: The law requires that the death certificate be executed redeath. setor: After this certificate has been signed by the attending physicien and by the integral physicien and by the integral physicien and setonid has deschad for use as the burial transit.	by Physician/Medic		23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			birth 2 [Fetal death		Ectopic p		/					te of delik	rery Day Year
s that	> P	F	Part II. Other significant co	onditions c	ontributing to d	death but n	ot resulting in	the un	derlying	ause giv	en in Part	I.	23e. Did	tobacc	o use cont	ribute to	the cause of death?
ords													1] Yes	200 No	3 Pro	babiy 4 Unknown
Recc The law r	D	-											24a. Wha aut per 1 ☐ Yes	opsy formed?	,		opsy findings available ompletion of cause of 2 No
Vital Filician: The contificate	Be	1 2	25. Was case referred to mexaminer?	edical							26. Plac	e of Deat	h (Check only	-			
of V Physic this ce	2	L	1 ☐ Yes 2 No			Inpatient	2 ☐ ER/Out	_			4 🗆 14	ursing Ho	me 5 Re	sidence	6 □Oth	er (Spec	fy)
OD C ding P After t	ion:	1		Pending nvestigation		of Injury oth, Day Ye	28b. Ti	ime of jury	м 2	28c. Injur Wor	yat k? Yes 2.⊑	1No	28d. Describe	how in	iju ry occur	red	
E Parte	Certification:		3 Suicide 6 0	Could not be determined	28e. Place	e of Injury	- At home, far Specify)	m, stre					28f. Location City or T			er or Rui	al Route Number,
To the Hospital within 24 hours a To the Funeral Incompletel Holden	Medical Ce	-	(Check only 2 Ma	rtifying Ph	ysician: To th	basis of exa	amination and	death	occurred	at the tir	me, date a	nd place, ath occur	and due to th	e cause	(s) and ma	anner as and due	stated. to the cause(s)
thin 2	Med	-	one) 29b, Signature and title of		and mar	nner stated	i.				e number						Dey, Year)
¥ ½ ¥ 8		1	V 0	16	0 0	full	-1.5	`		Dar	122	CO-		(Qu	wil	9	2007
20		3	30. Name and alto ess of p	er on who	completed cau	ise of death	n (Item 23a) (/ Type, f	Print)		JAI	30C	,	J-1	5	1	0 - 0 /
יחי		9	G. 1 T	Diami	-h-1+	Midat	-lontic	C	\rdio	W12 C.C	milar	Agg	C .	Ra1	timor	e.MD	.21229

State Registrar DHMH 17 Rev 1/2001

Stephen J.Plantholt

31. Date filed (Month, Day, Year)

APR 1 1 2007

Midatlantic CArdiovascular Assoc.

Baltimore, MD. 21229

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** JOHN RONALD FRAZIER APRI 2007 6:50 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Saint Joseph Medical Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months 1**☑**M 2□F Maryland Mar31, Director 218-32-6917 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore County Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 6521 Banbury Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) Baltimore City ene. Elementary/Secondary (0-12) College (1-4or 5+) Fire Department 3 y<u>rs</u> Fire Commander permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygic Important: If item 27 is marked other I any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John McHenry Frazier Atoinette Smith ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6521 Banbury Road, Baltimore, Maryland 21239 Janet L. Frazier (Wife) altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 4/10/2007 Pikesville, Maryland 21. Signil Fugeral Since Lice see

Martin D. Lawson 22.Name and Address of Facility MITCHELL-WIEDEFELD FUNERAL HOME, 6500 York Road, Baltimore, Maryl 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ACUTE MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): attending physician for use as the burial Division or Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an ate has bage 2 s autopsy performed 2 **N**o 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☑ npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 Yes 2 No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D30263 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 FRANCIS KHOO. M. D. 31. Date filed (Month, Day, Year) 62. Registrar's Signature State APR 1 1 2007 Registrar

DHMH 17 Rev 1/2001

			1 = For State Registrar			partment of I certificate of		Re	g. No.	11391
	Physic /Medi		1. Decedent's Name (First, Middle, La Hedwig E. (·				2. Date of Death Month April	8, Day 2007 Year	3. Time of Death 8:00 A M
	Examir		4a. Facility Name (If not institution, given Augsburg Luther)				or Location of Death Learn		4c. County of Death Baltimon	re
	Funeral Director		5. Social Security Number 216–28–3680		e (In yrs. last birthd 89 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 15	Year) Coui	
	Maryland a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltir	more	10c. City, Town or Loche					10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	th with the 23a or 28s	Dire	10e. Street and Number 6825 Campfield Ro	oad #10R		10f. Zip Code	21207	10	g. Citizen of What Coul	ntry?
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "netural", or Iteme 23a or 28a-f ehow aumatic event, the Medical Exendrate must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🕅 N If Yes, Give Year or Dates:		3. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☑ No		ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
Maryland 21215-0036	within 72 ho iene. then "netui the Medical	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or 5	i+) (G	ecedent's Usual Occupion of work done of work done of work done of DO NOT use retire	pation during most of work d)	ing	6b. Kind of Business/In Own Home	dustry
land	ild be filed lental Hygie ked other ilc event, tt	To Be Co	17. Father's Name (First, Middle, Last Frederick Lutbe		III	omemaker	18. Mother's Name	e (First, Middle, M	aiden Sumame)	
lary	2 should and Men le marke aumatic	-	19a. Informant's Name/Relationship (Type, Print)					City or Town, State, Zip	
	1 and Health em 27 ther tr		Rita F. Kirsch I	Personal Re	20b. Place of Di	sposition (Name of			ille, MD 21	
baltimore,	permit. Pages Depertment of I Important: If Its any Injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Service) Lice	2)		n Park	4/11	/2007 B	altimore, M	Maryland
g	Depe Impo		oubecs C	1 S		Funeral 1630 Edm	Home of Condson Av	atonsvil enue: Ca	hton Schwal Ie, Inc. tonsville,	MD 21228
	Care be executed by Physician and Medical Examiner and the purial-transit	edical Examiner	23a. Part1. Enter the disease, dy con- shock, or heart failure. Lictionly Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b.	A 17	enter the mode of dyll			10 March 10	Approximate Interval-Bactween Onset and Death
P.O. Box 62	ath certi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregnanc; 5 □ Other (specify) □	у		23d. Date of delive Month	ery Day Year
	w requires that the de been signed by the a should be detached f	þ	Part II. Dther significant conditions	contributing to death bu	ut not resulting in the	e underlying cause gr	ven in Part I.		acco use contribute to the	
Vital Records,		Completed						24a. Was an autopsy perform	prior to co	psy findings available mpletion of cause of
	Physician: Th rthis certificate ral director, pag	o Be	25. Was case referred to medicat examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2□ER/Outpa	tient 3 DOA Ott		Check only one		
to not	grange of the second	 	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injur (Month, Day	v 28b. Time	e of 28c. Injur	4 Zelivuising no	28d. Describe how	ce 6 Other (Specific injury occurred	y)
DIVISION	itel or Atters after de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		iry - At home, farm, c. (Specify)	street, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Aedical	(Check only 2 Medical Examone)	nysician: To the best of miner: On the basis of and manner sta	examination and/or	r investigation, in my o	opinion, death occurr	ed at the time, dat	use(s) and manner as s e and place, and due to	the cause(s)
,	5 Will	M	29b. Signature and title of certifier 30. Name and address of person who	completed cause of de	Path (Item 23a) (Typ	29c. Licens	872	Ay.	d. Date signed (Month,	Day, Year)
P	Sta		31. Date filed (Month, Day, Year)	BVB 2	S MO	ii st	216	36		
DHN	Registr		APR 1 1 200	17 Beauce	H. A					

DHMH 17 Rev 1/2001

Roy G	Goodwin		State of Maryland / E	Department of Certificate of		Mental H	łygiene	20	07 11392
	Physici		Registrar 1. Decedent's Name (First, Middle,Last)	Certificate of	Dealii		2. Date of Dea		3. Time of Death
Mędi	cal Exami	ner	Roy Goodwin				Month April 4, 20		2339 1118
أري			Facility Name (if not institution, give street and number) Southern Maryland Hospital		4b. City, Town, or t Clinton	ocation of Deat	th	4c. County of Prince G	
	Funeral			n yrs. last birthday)	if Under 1 Year				Birthplace (State or
	Director		061 42 4880 ₁ X _{M 2} F	47 Yrs	Months Days	Hours Mi	n. May	7, 1959	Foreign Country) New York
	á	-	Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town or Locat	ion				10d. Inside City Limits
	nd show a ce.		Maryland Prince George	- ·	Marlbor	о.			1 Yes 2 XXNo
	Maryland 28a-f show any d at once.	Director	10e. Street and Number		10f. Zip Code		1	10g. Citizen of Wha	
	5-UUSO for within 72 hours after death with the Maryland yygene. other than "natural", or items 23a or 28a-f sho the Medited Examiner must be notified at once.		8534 Biscayne Court		207			United S	
	death wi	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 XX	lf Y	is Decedent of Hisp es, specify Cuban,			0- 14. Race - White,	- American Indian, Black, , etc.
	after de	by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates:	No 1	Yes 2X No	specify:		Specify:	White
	hours a		15. Decedent's Education (Specify only highest grade comple	eted) 16a. Deceder during m	it's Usual Occupations of working life.			16b. Kind of Bus	siness/Industry
9	hin 72 e. than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Family	History	Consul	tant	Geneo1	Logy
2424E 002E	LILIO-0000 uld be filed within 72 hours afte Mental Hygiene. marked other than "natural", c event, the Medical Extinine	S	17. Father's Name (First, Middle, Last)			8.Mother's Nam	ne (First, Middle,	Maiden Surname)	
104	be fi ntal rked ent,	B B	Roy C. Goodwin	celia	mber, City or Town	State 7 Code)			
נים	2 should h and Me 27 is ma	입	19a. Informant's Name/Relationship (Type, Print) Barbara Goodwin (Wife)						, State, 2ip Code)
?	- 94 5 6 1	ı	20a. Method of Disposition	20b. Place of Dispos	sition (Name of cem	netery,	Date	20c. Location -	City or Town, State
8	Pages nent of ant: If	1	1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	Glenwood	Cemeters	April	11, 200	Geneva	a, New York
3100	Dalumore, permit. Pages I an Department of Hea Important: If iter injury or other tr.		21 Signature of Funeval Service Licensee	22. N	lame and Address	of Facility Lee	Funera	1 Home,I	nc 6633 01d
	Physician		23a. Part I. Enter the disease, or complications that caused the	A1	exandria he mode of dying, s	Ferry B	cad, C1 or respiratory ar	inton M rest, shock, or hea	nt 2 mate Interval
	Medical	0 8	failure. List only one cause on each line. Immediate Cause (Final disease a. Cardiac tamp	onade					Between Onset and Death
-	Examiner		or condition resulting in death) Due to (or as a consequ	ence of):					
		ē	sequentially list conditions, if any, leading to immediate b. Ruptured aor Due to (or as a consequence)		on				
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	The lar	Completed							eath? Yes 2 No
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	ION (tending eath. or: All the fur	lig	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	1 Y	es 2 No	-		
	IVISI lor Ati after da Direct I in by	Certification:	3 Suicide 6 Could not be 28e. Place of Injury	y - At home, farm, stre	et, factory, office b	uilding, etc.	28f. Location or Town,		er or Rural Route Number, City
	Hospital 24 hours a Funeral I		4 Homicide determined (Specify) 29a. Certifier Check only 1 Certifying Physician: To the best of my k	nowledge death occu	rred at the time da	ate and place ar	nd due to the cau	use(s) and manner	as stated
	LIVISION Of VICAL RECORDS, P.O. BOX 86/01 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	Medical	one) 2 Medical Examiner: On the basis of examinary and manner stated	nation and/or investiga	ition, in my opinion,	, death occurred	at the time, date	e and place, and d	ue to the cause(s)
	5.358	Me	29b. Signature and title of certifier	/	29c. License				ed (Month, Day, Year)
			W. H		0.C.I	И.Е.		April 6, 200) <i>(</i>
	0		30. Name and address of person who completed cause of dea Jack Titus MD. Deputy Chief Medical Exa		nn Street, Balt	imore, MD 2	21201		
	S	tate	of Bulling and Bulling					-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month < **Physician** George Gladden 111 V. 200 /Medical 4c. County of Death, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner dale rare 05 ita 0 01 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Jan 29, 1 6. See 7. Age (In yrs. ast birthday) 5. Social Security Number Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 XM 2 □ F Maryland ,1950 213-60-5407 57 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Examiner must be notified at 1 ☐ Yes 2X ☐ No Director MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or USA 48 Rocky Wood Lane 21221 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Notes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 'natural", or 1 ☐ Yes 2 🗷 No Specify: White ģ 3 ☐ Widowed 4 € Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printing permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygiene Important: if item 27 is marked other tha any injury or other traumatic event, the 1 and once. Pressman <u> 12th</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George V. Gladden Jr. Catherine Barton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Gladden /mother 48 Rock Wood Lane Baltimore MD 21221 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State Gardens of Faith 4/7/07 Baltimore MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature Duneral Service Licensee 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex Approximate Interval Between Onset and Death ators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line, 23a. Part1. Enter the disease, or shock, or heart failure. List or con Immediate Cause (Final Oac Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown ģ cate has been signed, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours a er death To the Funeral Director: filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland / Be	epartment of Health and Sertificate of Death		eg. No.	1100
	Physic	an	1. Decedent's Name (First, Middle, Last)			2. Date of Deat Month	Day Year	3. Time of Death
	/Medi		Gertrude	E.	Gillis	April	5 2007	
	Exami	ner	4a. Facility Name (If not institution, give s		4b. City, Town, or Location of D	eath	4c. County of Death	
	- Francisco		Hopkins Assiste 5. Social Security Number 6. Sex		Edgemere av) If Under 1 Year If Under 24 I	Hrs. 8. Date of Birth	Baltim 9. Birth	
Н	Funeral Director			M 2♥F 91 Yrs	Months Days Hours N	1in. (Month, Day,	Year) Cou	nplace (State or Foreig untry) V A
	p		Usual Residence of Decedent			04 05	1.0	
	arylar show	_	10a. State 10b. County	10c. City, Town or	r Location			10d. Inside City Limits
	8e-f	Director	MD NA	Balt:	imore			X□Yes 2□N
	a or 2	급	10e. Street and Number	and Channe	10f. Zip Code	11	Og. Citizen of What Cou	•
	leath	Funeral	3024 East Feder		21213 3. Was Decedent of Hispanic Origin?	(Specify Yes or No-	U . S . A	
21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. 33 or 28e-f show event, the Medical Examinar must be notified at event, the Medical Examinar must be notified at	by	1 □ Never Married 2 □ Married 3 □ Widowed 1 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pr □ Yes 2 ☒ No Specify:	uerto Rican, etc.)	Black, White	
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Maryland	should be filed within of Mental Hygiene. marked other than matic event, than M	Be	Arthur Aruther Harriso	n		Name (First, Middle, M Daniel	Maiden Sumame)	
ž	s 1 and 2 should if Health and Mer item 27 Is marke other traumatic	2	19a. Informant's Name/Relationship (Ty)				City or Town State 7	in Code)
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	s 1 and of Health item 27 other tr		20a. Method of Disposition	20b, Place of Dis	sposition (Name of	The second second second	20c. Location - City or T	
OL.			1 ☑ Burial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	rematory or other place) s Memorial 4/	10/07	Arbutus,	MA
Baltimore,	permit. Page Department o Important: If eny injury or ence.		21. Signature of Funeral Service Licents	99	22. Name and Address of Facility	10/07	ALDUCUS,	na
ä	Depa Impo eny i		(Xala)	March !	March F/H West 4300 Wabash Av	a. Baltin	nore. Md	21215
	/Medical Examiner	aminer	23a. Part1. Eyer the disease, or complishook, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	e cause on each line.	inona (unk		rinary)	Approximate Interval Batween Onset and Death
Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	lan/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		3 Ectopic pregnancy 5 Other (specify)		23d. Date of delive	rery Day Year
P.O.	the de y the ched	yslo	1 ☐ Yes 2 No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5 Unter (specify)			
	res that igned by be deta	y Ph	Part II. Other significant conditions con			23e. Did tob	acco use contribute to	the cause of death?
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of Vital Records,	hysicien : The law requir his certificate has been si I director, page 2 should I	Completed by Physician/A	renal insu	freiency		24a. Was ar autops perform 1 Yes 2	v prior to co	opsy findings available ompletion of cause of
ta	en: Trifica	0	25. Was case referred to medical		26. Place of I	1 Yes 2 Death (Check only one		20110
>	Physicien: r this certifica ral director,	To B	examiner? 1 ☐ Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	tient 3 DOA Other: 4 Nursin	g Home 5 Reside	nce 6 Other (Speci	MASSIST
Division o	ling P. After t funera		27. Manner of Death 1 Satural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe ho	w injury occurred	Living
Divi	itel or Attendi ins after death. rel Director: A led in by the fa	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Str City or Town	reet and Number or Rur , State)	al Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical	(Check only 2 Medical Examin	ician: To the best of my knowledge, de er: On the basis of examination and/or and manner stated.	investigation, in my opinion, death o	ccurred at the time, da	ate and place, and due t	to the cause(s)
	To To	Σ	29b. Signature and title of certifier	0	29c. License number		d. Date signed (Month,	
,			M. mu				prel 6	2007
_	2		30. Name and address of person who con	mpleted cause of death (Item 23a) (Type CNLL ney 4946	De Print) Destern Au	Bulh	mane MD	21224
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar's Signature				

DHMH 17 Rev 1/2001

State Registrar

GERTRUDE

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤉 🗍 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Rebo 8:30 PM 28 larch 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner lar Force binger Irail 6. Sex If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 M 48 June 29 1958 219-78-8374 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show at 1 ⊈Yes 2 No must be notified Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò and 2 should be filed within 72 hours after death with ural", or items 23a Examiner must b binger 21040 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: 3 Widowed 4 Divorced 'natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nursino 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be Menta is marked ghe. elano 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zie Code) 19a. Informant's Name/Relationship (Type. Print) 21040 Bi nt of Health T06 1491 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 24B Cremation 5 3 ☐Removal from State Department of Important: If any injury or once. 5 Other (Specify) 21. Signature Fune | Service Licensee 22. Name and Address of Facility 1237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) TERMINAL **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical as 1 IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 5 ☐ Other (specify) P.O. been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ho 24a. Was an certificate has birector, page 2 s autopsy performed 2 10 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1445931 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Doborah 32. Registrar's Signature 31. Date filed (Month, Day, State APR 1 1 2007

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of N	iaryiano		artment of F rtificate of			,	giene Reg. No. 🕜 🍸	~ /~ ~~	1 1 5 5
			Decedent's Name (First, Midd	le, Last)					2. [Date of De	ath C	J U/	3. Time of Death
	Physic /Medi		JOHN G. GINN							Month	Day	2007	10:10 AM
	Exami	ner	4a. Facility Name (If not institution	1 1 1) 1 1-	1	4b. City, Town, o	r Location	of Death	1	4c. County	^	1 1
			5. Social Security Number		ge (In yrs. Ia	nier	If Under 1 Year	If Unde	MUL er 24 Hrs. 8, p	Date of Birt		2 1/1	undel
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	Mar a-f sh ified	tor	MARYLAND ANNE	ARUNDEL	GLEI	N BURI	NIE						1 □Yes 2XNo
	or 28	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Cour	ntry?
	death with the Maryland ms 23a or 28a-f show r.must be notified at	ra	907 AMELIA AVE				2106				UNITED		
21215-0036	be filed within 72 hours after death with the Marylar tal Hygiene.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 🏋 Divorce	If Yes, Give	No	1	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ※ No			Yes or No in, etc.)	- 14. Had Blad Specif	ce - Americ ck, White, y: WH	
20	72 ho natur lical I	sted	15. Decede	nt's Education	- 1	16a. Dece	dent's Usual Occup	ation	est of working		16b. Kind of B		
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Maryland		Be c	JOHN C. GINN	, Last)							Maiden Surnar	ne)	
<u> </u>	should be fund Me tall he mark of	မ	19a. Informant's Name/Relation	ship (Type, Print)		19b. Maili	ng Address (Street		EN O. C.		er City or Town	State Zir	(Code)
Za			CHERYL KEETER				PINE CON						,
re,	ges 1 and 2 should tt of Health and Me If Item 27 is mark or other traumatic		20a. Method of Disposition			ace of Dispo	osition (Name of matory or other pla		Date		20c. Location		
E	Page nent c int: if		1 □ Burial 2 ② Cremation 4 □ Donation 5 □ Other (3 ∐Removal from State Specify)	e		EMATORY,	· .	APRIL 9		CATONSV	ILLE,	MARYLAND
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.		21. Signature of Funeral Service	Licensee		K]	2. Name and Addre I RKLEY-RU 21 CRAIN	DDICE	K FUNER	AL HO	ME, P.A		
	NEW T	Г	23a. Part1. Unter the disease, of shock, or heart failure. Lis	r complications that cause	ed the death.							, MD_	Approximate Interval Between
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В	Examiner	L	Sequentially list conditions,	b. 230P		3n_	CANC	? /					
	St. A. e.	ine	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consique	ence of):							
	and and al-tran	Examiner	that initiated events resulting in death) Last	c Due to (or a	s a conseque	ence of):							
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687	ritificate be executed ng physician and sas the burial-transit	edical		0.									
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ita		Be C	25. Was case referred to medic examiner?	al				26. Plac	ce of Death (Ch			1 1 1 6 3	2 140
<u>-</u>	Physic this ce al direc	To E	1 Yes 2 No	Hospital:	tient 2 E	R/Outpatier	nt 3□ DOA Oth	er: 4□N	lursing Home	5 🗆 Resid	dence 6 □Oth	ner (Specif	y)
Division or	Ing		27. Manner of Death 1 Natural 5 ☐ Pendi	28a. Date of In (Month, D		28b. Time o Injury	Wor			Describe I	now injury occur	red	
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Σ	lor A after o Direc	Certification:	4 ☐ Homicide deter	ninod Zoe, Flace Ul II	etc. (Specify)	ne, iarm, su	eet, factory, office		281. 1	City or Tox	otreet and Numb vn, State)	er or Hura	I Route Number,
_	Hospita 24 hours Funeral	Medical Co	29a. Certifier 1 Certify (Check only one) 2 Medica	ng Physician: To the bes i Examiner: On the basis and manner s	of examination	ledge, deat on and/or in	h occurred at the ti	me, date a	and place, and eath occurred a	due to the	cause(s) and made and place,	anner as s	tated. o the cause(s)
	To the Hos within 24 ho To the Fun completely	Me	29b. Signature and title of certifi				29c. Licens				29d. Date signe		
-			Henn	Franci	M		00	274	115		Amil 1	6,2	007
	5		30. Name and address of person	who completed cause of	death (Item 2	23a) (Type,	Print) WASH	NOT	nal Ma	الخدر ا	TPN	tec	•
	Sta	ate	31. Date filed (Month, Day, Year) 2. Regis	trar's Signatu	ire	- 1/0 F/1	, v <11 <u>(</u>	110 1:18		U.P.	Y	
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		1	State of Maryland / D State Amend #31, perDVR, g866, 4/11/07 TT Registrar	epartment of Health ar Certificate of Death	nd Mental Hyg R	jiene leg. No.co o o o	11007
.55	Physicia		1. Decedent's Name (First, Middle, Last) Patricia Anne Griffen		2. Date of Dea	th Day Year 3, 2007	3. Time of Death / 8:58P M
**************************************	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of	Death	4c. County of Death	mayaa
			St Joseph Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birt.	TOWSON hday) If Under 1 Year If Under 24	4 Hrs. 8. Date of Birth	Balti	place (State or Foreign
	Funeral Director		S. Coolai Coolai y	rs. Months Days Hours	Min. December	7,1942 Mary	l'l'and
- A	D.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		1	Od. Inside City Limits
	daryla f shov led at	_	Maryland N/A Balti	more			1 XX es 2 □ No
	n the l	irect	10e. Street and Number	10f. Zip Code		10g. Citizen of What Cou USA	ntry?
	ath wit	ral D	1341 Meridene Drive	21239	in? (Specify Yes or No-		can Indian,
92	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Directo	11. Marital Status 1 ★ Never Married 2 Married Armed Forces? 1 □ Yes 2 ★ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 ☐ Yes XX No Specify:	Puerto Rican, etc.)		etc. nite
21215-0036	2 hours atural' cal Ex	ted b	15. Decedent's Education 16a.	Decedent's Usual Occupation (Give kind of work done during most	of working	16b. Kind of Business/Ir	ndustry
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lano	lld be flental ked o	To Be	Guy Glenn Griffen Jr		argaret Ann		
Maryland	2 shou and N is mai			. Mailing Address (Street and Number 1229 Ramblewood Ro			
	is 1 and 2 of Health a item 27 is other trau		20a. Method of Disposition 20b. Place of	Disposition (Name of ry, crematory or other place)	Date	20c. Location - City or T	
mo	Pages nent of int: if its ury or o	1	Cernete	y's Cemetery	4/11/07	Baltimore,	Maryland
Baltimore,	permit. Departmine importa any inju		21. Signature of Funeral Service Licenses	22. Name and Address of Facility 6500		edefeld Funeral Itimore, Maryla	
		1	23a. Part1. Enter the discress, or complications that caused the stath. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as	cardiac or respiratory a	rrest,	Approximate Interval Between Opent and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence	ASEMAN	Model	asi	2 Mes
è	nted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	of):			
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Records,	red beer shou	Completed	And Makelesk	releant	24a. Was auto perfi 1 Yes	ormed? death?	utopsy findings available completion of cause of 2 ☐ No
Vital	cian: ertifica ector, p	BeC	25. Was cast referred to medical examiner?	26. Place	e of Death (Check only		- ")
or	Physician: r this certific ral director,	은	1 Yes 20 No 1 Inpatient 2 TR/O	Time of 28c. Injury at		sidence 6 Other (Spe how injury occurred	city)
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Division	I or Atter after dea Director	ertifica	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, 1 building, etc. (Specify)	arm, street, factory, office	28f. Location City or To	(Street and Number or Ri own, State)	ural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	edical Certification:	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge and manner stated.	ge, death occurred at the time, date a and/or investigation, in my opinion, de	and place, and due to the eath occurred at the time	e, gate and place, and du	e to the cause(s)
	~	Me	29b. Signature and title of sertific A A A A A A A A A A A A A A A A A A A	29c, License number	1622	29d. Date signed (Moh.	th, Day, Year)
	10		30. Name and address of person who completed cause of death (tem 23a	Xfo York	RD 64	mfort,	un
	S Regis	tate	11/4/2	2007 filesure di	Sports		

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1/ber /Medical 4b. City Fown, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthdav) 9. Birthplace Country) 5. Social Security Number 6. Sex **Funeral** 1 №M 2 🗆 F Min Months Hours 554-74-5204 Usual Residence of Decedent Director 0 with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Pres 2 □ No MD Roseda Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2123 death v by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumate. ☐Yes 2☐No Yes, Give 1 ☐ Never Married 2 ☐ Married African 1 ☐ Yes 2 ☑ No Maryland 21215-0036 Yes, Give ear or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced America Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) JM motone -abone 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) ANN Hill atricia W. Fe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City 1 ☐ Burial 2 ☑ Cremation 3 □Removal from State Bay view Crematory 5 ☐ Other (Specify) 4 ☐ Donation Name and Add 21. Signature of Furieral Service Licenses 17an, 5126 21206 oad 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Du (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9☐Unknown 9 ☐ Unknown cate has been signed by t page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe After this certificate 2 No 1∐ Yes or Attending Physician; 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the f within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 9000

DHMH 17 Rev 1/2001

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 40 **Physician** EAWOR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. Birthplace (State or Foreign Country)
 , curity Number vrs. Jast birthday Date of Birth (Month, Day) **Funeral** Months Days Min 1 □ M 2 🕏 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Nes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race -American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ò 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industr (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) UNKUOWI permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any lipiny or other traumatic event one. 17. Father's Name (First, Middle, Last) Be 10WN 19b. Mailing Address-(Street and Number or Rural Route Number, City or Town, State 19a. Informant's Name/Relationship (Type. Print) Zip Code) of Disposition 20b. Place of Disposition (National Communication) 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dechne **Physician** /Medical Due to (or as consequence of) Examiner Brythme Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nse wence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) burial physician s the burial Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a Ö 9 Unknown 9 Unknown signed by t م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 2□ No 3 Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 this certificate 1□ Yes 2 100 or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Norsing Home 2 ER/Outpatient 1 Tes 1 🔲 Inpatient 3□ DOA Certification: To 5 Residence 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Division To the Hospital or Attending 1 ⊟Natural 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) MID 31464

Registrar

State

SHOAIB

31. Date filed (Month, Day,

N

821

EUMN ST fonte 300 BALTIMINE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hm1 mD

32. Registrar's Signature

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Year)

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			For State Registrar	State of Ma		epartme Certifica			d Menta	I Hygie _{Reg.}	C001	11400
			1. Decedent's Name (First, Middle, L	.ast)						e of Death		3. Time of Death
	Physici /Medi		Lucille E.	. Hoilman	n				Moi Ap:		Day Ye	
	Examir		4a. Facility Name (If not institution, g			4b. Ci	ty, Town, o	r Location of D			4c. County of D	
			Greater Baltimo	ore Medical	Center	r	'owson	1		-	Baltin	nore
	Funeral			Sex 7. Age	e (In yrs. last birt	hday) If Und	der 1 Year	If Under 24	Hrs. 8. Date	of Birth		Birthplace (State or Foreign
	Director		212-44-3161	1 M 2 F	58	Yrs. Month	s Days	Hours N	Apr	"i115	,1948	Couintry) MD
	p ,		Usual Residence of Decedent									
	aryla shov	_	MD Balti	m =	10c. City, Town							10d. Inside City Limits
	88-f	octo		шоге	Ess	ex						1 ☐ Yes 2 🛣 No
	death with the Maryland ms 23a or 28a-f show In ust to notified at	Director	10e. Street and Number			10f. 2	Zip Code			10g.	Citizen of What	: Country?
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. 1	er de	Funeral	11. Marital Status	12. Was Decedent if Armed Forces?		13. Was Dec	cedent of H pecify Cuba	lispanic Origin? an, Mexican, Pi	? (Specify Ye: uerto Rican, e	s or No- itc.)		mericen Indian, Vhite, etc.
യ്ക	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	10		2 N O	Specify:				
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್ರ ಸ	within 72 hours after ene. than "natural", or Ite ne Medical Example.	Completed	15. Decedent's (Specify only highest g		16a.	Decedent's U: (Give kind of i life, DO NOT	work done o	during most of	working	1	o. Kind of Busine	
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	filed Hygi Sther ent.	Ö	17. Father's Name (First, Middle, Las	st)				18. Mother's	Name (First.	Middle, Mai	den Sumame)	
<u>a</u>	ld be ental ked c	To Be	Henry Wayson								,	
2 5	should nd Men marke umatic	-	19a. Informant's Name/Relationship		19b.	Mailing Addre	ss (Street		Moor		ity or Town, Stat	e Zin Code)
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2 2	Pages nent of I ont: If it		Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	☐Removal from State	Hoilm	v, crematory o	r other plac neter	4	/19/07	7		
HENNOW altimore, Maryland			21. Signature of Funeral Service Lice					es of Equilibr				ille NC
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			23a. Part1. Enter the disease, or con	nolications that caused	the death. Do no	Conr	nelly	Fune	ral H	ome c	of Esse	Alto MD Approximate Approximate
			shock, or heart failure. List onl Immediate Cause (Final	y one cause on each lin	ιθ.		3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	g, 040// 40 04/	aido or roopire	anosi,		Interval Between Onset and Death
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Вох	eath certifi attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy						23d. Date of	delivery
m	death atte	cia	in the past 12 months?	1 ☐Live birth : 4 ☐ Pregnant at :		3 ☐Ectopic 5 ☐ Other (Month	Day Year
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<u>α.</u>	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	y PI	Part II. Other significant conditions	contributing to death bu	it not resulting in	the underlying	cause give	en in Part I.	23e	. Did tobacc	co use contribute	e to the cause of death?
rds	quires n sign	Completed by	Mediastinal lymp	hadenopathy	У					1 🗆 Yes	2 No 3	Probably 4 Unknown
8	w require been sign should t	lete							24a	Was an	24h Wara	autorsy findinge available
Re	sician: The law certificate has t irector, page 2 s	mc							-	autopsy performed	? death	
Ta Ta		e C	25. Was case referred to medical	1						Yes 2	No 1 🗷 Y	es 2□No
5	Physician: this certificatal director, p	8	examiner?	Hospital:	* 3 D EB/O		Othe	26. Place of [
Division of Vital Records, P.O	Phy or this aral d	: To	27. Manner of Death	28a. Date of Injury (Month, Day			28c. Injury	4 Nursing			6 Other (S	pecify)
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<u> S</u>	Attendir death.	flee	3 ☐ Suicide 6 ☐ Could not	286. Place of inju	ry - At home, farr	n, street, facto	ory, office		28f. Loca	ition (Street	and Number or	Rural Route Number,
Ď	afte a afte i Dire	Certification:	4 Homicide determined	building, etc.	. (Specify)				City	or Town, St	tate)	
	Hospitel	a	29a. Certifier 1 Certifying P	hysician: To the best o	f my knowledge,	death occurre	d at the tim	e, date and pla	ace, and due	to the cause	e(s) and manner	as stated.
	To the Hospitel or Attending PP within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner stat	examination and	or investigation	n, in my op	oinion, death or	ccurred at the	time, date a	and place, and o	lue to the cause(s)
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Ž	29b. Signature and title of certifier	110	1	2	9c. License	number		29d. I	Date signed (Mo	onth, Day, Year)
			Thelink.	Us June 11	(Mi)		D472	21			04/10/2	007
	0		30. Name and address of person who	completed cause of de	eath (Item 23a) (T	ype, Print)					0-1/ 1U/ Z	007
	Ψ		Philip R. McDowe	ell, M.D	GBMC 67	01 N C		s Stree	et; Bal	timor	e MD 21	204
	Sta	te	31. Date filed (Month, Day, Year)		r's Signature							
	Registra	ar	APR 1 1	2007	the Sh	A COLARE						

07-02593	
Raymond J. Ho	Iston

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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POLICIAL Examination 4. Facility Numer (Proclamation JOSEPH MOLSTON JR. 4. Facility Numer (Proclamation JOSEPH MOLSTON JR. 4. Facility Numer (Proclamation JOSEPH MOLSTON JR. 4. Facility Numer (Proclamation Joseph Service) Foundation 5. Second Second Policy Numer (Proclamation Joseph Service) Foundation 5. Second Second Number (Proclamation Jr. 5. Second Second Number (Proclamation Jr. 5. Second Second Number (Proclamation Jr. 5. Second Second Number (Proclamation Jr. 6. Second Number (Proclamation Jr. 6. Second Number (Proclamation Jr. 6. Second Number (Proclamation Jr. 6. Second Number (Proclamation Jr.			1- For State Registrar	,	Ċertific	ate of	Death			Reg.	No.	,	, , , ,
RAYBOUND JOUS PH HOLSTON JR		an/	1. Decedent's Name (First, Middle,							of Death	-	.	
Franchic Square Hospital Franchic Square Hospital Franchic Code Salective Number Case Salety Number Salety Number Case Salety Number Salety	nedical Exami	ner			ON C		h City Town or I		April	5, 2007			0/29 nrs
216 5 2 7 5 82 X u 2 4.9 Yu.			Franklin Square Hospit	al		,	Rosedale				Baltimore	e County	•
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The control of the	the Mary a or 28a- tified at o	Direct		AVE			· ·	7		10g.		•	?
18. Melling Address (Sreat an Number of Furial Rade Number, City or Town, State, Tip Code)	after death with al", or items 23 iner must be no		1 Never Married 2 X Man	ried Armed Forces?		If Yo	es, specify Cuban,	Mexican,			14. Race - White,	- American , etc.	
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18. Melling Address (Sreat an Number of Furial Rade Number, City or Town, State, Tip Code)	215 be file ntal H.		RAYMOND J. H	OLSTON SR				VIV	IAN	GO	OD		
Physician Phys	hould of Mer						•			ute Number	r, City or Town	, State, Zir	p Code)
Physician Phys	nd 2 sl alth ar			LSTON/WIF						TIMO	RE, M	D 21	237
Physician Medical Xaminer 23a Part Letter the disease, or complications that caused the death. Do not enter the memory of dying, such a cardiac or respiratory area, shock, or heart immediate clause (Final classes or complications that caused the death. Do not enter the memory of dying, such as cardiac or respiratory area, shock, or heart immediate clause (Final classes or injury that initiated worths resulting in death) Sequentially, it conditions. Sequentially, it conditions. Sequentially, it conditions. Sequentially, it conditions. Sequentially, it conditions. Sequentially, it conditions. Sequentially, it conditions. ANDERDO V. ANSENDED If FEMALE. 23c. If yes, outcome of pregnancy 1 we so 2 No 9 Unknown 1 we so 2 No 9 Unknown 25c. Was case referred to medical accurate. Earth of the cause of death? 1 we so 2 No 9 Unknown 25c. Was case referred to medical accurate. The sequential and the sequenti	timore t. Pages 1 a tment of He rtant: If ite		1 X Burial 2 Cremation 4 Donation 5 Other Spe	cify:	to crema	tory or oth ENS	of FAI	ГН	4/11/0	7 B	ALTIM	ORE,	MD
Physician Medical	Bal permi Depar Impo		21. Signatoke of Funeral Service Li	censee		22. N	ame and Address	of Facility	CVACH /	ROSE	DALE	FUNE	
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The contribution of the co	cuted and transit	al Exar		Due to (or as a conse	quence of):))
25. Was case referred to medical examiner? 1), be exe sician a urial -	dic	X UNPENDED	X AMENDESa, 27,	perME,g86	57,5/2	5/07 TT						
29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) April 5, 2007 30. Name and address of person who completed cruss of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 29c. License number O.C.M.E. 4pril 5, 2007 April 5, 2007	X 6876C th certificate trending phys	₹	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 Live birth 4 Pregnant at t	ne of pregnancy	Pet	al death 3	Ectopic	pregnancy				Year
29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) April 5, 2007 30. Name and address of person who completed cruss of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 29c. License number O.C.M.E. 4pril 5, 2007 April 5, 2007	. BC	hys		9 Onknown	but not reculting	a in the cu		unn in Doe	220	Did toboo	and the contrib	uto to the	cause of dooth?
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30. Name and address of person who completed cruss of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 22. Registrar's Signature		ž	29b. Signature and title of certifier				1			29	d. Date signed	d (Month,	Day, Year)
Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 42. Registrar's Signature			Theodore 1			~?	O.C.M	1.E.		A	pril 5, 2007	7	
State 31. Date filed (Month, Day, Year) 42. Registrar's Signature Registrar APR 1 1 2007			Theodore M. King, Jr., N	MD. Assistant Me	edical Exam	iner	111 Penn Stre	eet, Balti	imore, MD 2	21201			
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			State of Maryland /				-	_	•
			1- For State Registrer		tificate of L			eg. No. 0 0 7	11402
			Decedent's Name (First, Middle, Last)				2. Date of Deat	th	3. Time of Death
	Physicia /Medic		ALBERT HUNT, JR.				APRIL 7,	Day Yea 2007	1400 P ^M
1	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of De	
			ANNE ARUNDEL MEDICAL CENTER		ANNAPOLIS			ANNE ARU	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Sirthplace (State or Foreign Country)
	Director		251.66.9874 XX 64 Usual Residence of Decedent				OCTOBER 8	, 1942	SC
	nyland how		10a. State 10b. County 10c. City, To	wn or Loc	ation				10d. Inside City Limits
	e Ma 3e-fs	ctor	SC DORCHESTER SUMMER	VILLE					1 Yes 2 No
	vith th	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What	Country?
	eath v	erai	1524 DAWSON BRANCH RD. 11. Marital Status 12. Was Decedent Ever in U.S.	12 14	29483	enanic Origin? (Si	posity Ves or No-	USA	nerican Indian,
′0	fter d	Funerai	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give XX		/as Decedent of Hi Yes, specify Cuba		o Rican, etc.)	Black, Wi	
93	rel', o	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give XX Year or Dates:	1	☐ Yes ŽŽ No	Specify:		Specify:	LACK
5-0	be filed within 72 hours after death with the Maryland tall Hygiene. Add then "naturel", or items 23a or 28e-f show do other then "naturel", or items 23a or 28e-f show event, I'm Madical Examinar must be invitited at	Completed	15. Decedent's Education 16. (Specify only highest grade completed)	(Give k	ent's Usual Occupa	luring most of wor	king	16b. Kind of Busines	ss/Industry
121	within sne.	mp	Elementary/Secondary (0-12) College (1-4or 5+)		O NOT use retired,)			
р 2	e filed within al Hygiene. I other then ' vent, I' we	e Cc	12 17. Father's Name (<i>First, Middle, Last</i>)	IRU(K DRIVER	18. Mother's Nan	ne (First, Middle, M	MARINE Maiden Surname)	
au	should be nd Mental marked o imatic eve	ToB	ALBERT HUNT, SR.			EVA BENNE	TT		
ary	2 should and Mer Is marke eumatic	_		9b. Mailing	Address (Street a	and Number or Ru	ral Route Number,	, City or Town, State	, Zip Code)
Σ	1 and 2 Health tem 27 I				WSON BRANC	H RD. SUMM	ERVILLE, S	C 29483	
Baltimore, Maryland 21215-0036	Pages 1 and 2 should nent of Health and Men not: If item 27 Is marke iry or other treumatic		20a. Method of Disposition 1 □ Burial 2 XXCremation 3 XXemoval from State	of Dispos tery, crem	ition (Name of atory or other place	9)	Date	20c. Location - City	or Town, State
Ë	t. Pa rtmen rtant: njury				MATORY INC			BALTIMORE, N	
Bal	permit. Pages 1 and Department of Healt Important: If item 2 eny injury or other once.		21. Signature of Juneral Service Libensee	FIN	Name and Addres	HOME, P.A.	t/a MARYL	AND MORTUARY	SUPPORT
			K. GREGORY FINK M01148 23a. Part 1. Enter the disease, of complications that caused the death. Do shock, or heart failure. List only one cause on each line.		r the mode of dying				Approximate
	nysician		Immediate Cause (Final						Interval Between Onser and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence		Jointe				Surel 7
	Examiner		Sequentially list conditions b.						
	pe tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated execute.	e of):					
) _	be executed ician and burial-transit	хаш	that initiated events resulting in death) Last C. Due to (or as a consequence	e of).					1
,092	ate be executed sysician and he burial-transit	caiE							
687	death certificate by attending physic		d						
Вох	The Taw requires that the death certitical ate has been signed by the attending phy page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal deat	th 3 🗆	Ectopic pregnancy			23d. Date of c	delivery
<u>.</u>	e deal	sicia	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death		Other (specify)			Month	Day Year
P.O.	that the de led by the a detached f	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting	in the uni	do shifted a supplement	n in Dort I	220 Did toh	naga usa contributa	to the cause of death?
ds,	signed d be del	d by	Renal Cell Covinous	an the dire	derry ing cause give	mmranti.			Probably 4 Unknown
Soci	w requir been si should	iete					24a. Was ar		autopsy findings available
Vital Records,	he far e has age 2	Completed			-		autops	y prior to ned? death	o completion of cause of
	an: I	0	25. Was case referred to medical			26. Place of Dea	1 ☐ Yes 2 th (Check only one		es 2□No
\S	nysici lis cer direc	To B	examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/O	Dutpatient	3□ DOA Othe	<i>p</i>		nce 6 Other (Sp	pecify)
0 [ng Pr	on:		. Time of Injury	28c. Injury Work	at ?	28d. Describe ho	w injury occurred	
20	tendi death. tor: A the fu	cati	2 Accident investigation			′es 2 □No	00(1 1) 101		
Division of	after after Direct in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, founding, etc. (Specify)	rarm, stre	et, factory, office		City or Town	, State)	Rural Route Number,
_	to the hospitel or Attending Physician: The law within 24 hours all death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		29a. Certifier 1 Certifying Physicien: To the best of my knowledge	ge, death	occurred at the tim	e, date and place.	and due to the ca	use(s) and manner	as stated.
	n 24 h	Medical	(Check only one) 2 Medicel Examiner: On the basis of examination a and manner stated.	and/or inve	estigation, in my op	inion, death occur	rred at the time, da	ate and place, and d	ue to the cause(s)
	withi To t	Σ	29b. Signature and title of Certifier The Bulk My		29c. License	number > 46052		d. Date signed (Mo	
)			o franciscon 1		1	740032		41710	1
	6		30. Name appraddress of person who completed cause of death (Item 23a)	(Type, P	rine polical Po	nhway	annapol	is, HD	
	Sta Registra		31. Date filed (Month, Day, Year) APR 1 1 2007 32. April 1 2007	R	entre)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** PM JOANNA HENDRICKS APRIL 9 1410 /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LANDALLS TOWN NORTH WEST BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Virgina 1 ■ M 2 🗆 🕇 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits garyland 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be re 454 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☐ Newer Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Harbo 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill I Health and Mental H tem 27 is marked oth ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hendricks-son permit. Pages 1 and Department of Health Important: if item 27 any injury or other tr. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** sepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛂 No Day Year 5 ☐ Other (specify) ed by the a detached f 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has page 2 autopsy Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 | Yes 2 | No 2 Accident investigation death within 24 hours after death To the Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059736 7113 patrick MO April 9 2007

Registrar
DHMH 17 Rev 1/2001

State

DEBORAH

31. Date filed (Month, Day, Year) APR 1-1 2087 NURTHWEST HOSPITAL

LOURT ROAD

30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print)

ITZPATRICK

32. Registrar's Signature

WATSON

			Please	Type or Print in B					-	_).
			For State Registrar	State of Maryland		artment of F rtificate of		and M	, ,	mmm	11101
			Negistrar Necedent's Name (First, Middle, L.)	ast)		inicate of	Death		2. Date of Death	. No.	3. Time of Death
	Physici: /Medic		HELEN AGNE	S HUTSON					Month April	7, 2007	12:55 A. ^M
	Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, o	r Location o	f Death		4c. County of D	
		9	Stella Maris Hos	pice			onium			Balt	imore
	Funeral Director		5. Social Security Number 6. 218–14–2607 Usual Residence of Decedent	Sex 7. Age (In yrs. It 1 □ M 2 1 F 84	ast birthday) Yrs.	If Under 1 Year Months Days	If Under a	Min.	8. Date of Birth (Month, Day,) May 18,	'ear)	Birthplace (State or Foreign Country) Aryland
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	tor	10a. State 10b. County Maryland Baltin		Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h the	Director	10e. Street and Number	nore .	LTHOHL	10f. Zip Code			100	J. Citizen of What	Country?
	th wit 23a o Ist be	a D	2525 Pot Spring	Road L 710		210)93			U.S.A	
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of H	lispanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)		merican Indian,
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	16-500 Chro		1 □ Yes 2 🏋 No	Specify:		, ,	Specify:	
21215-0036	hour tural' al Ex	ed b	15. Decedent's	Year or Dates: 1944—		ient's Usual Occup	ation		16	6b. Kind of Busine	White
15	iin 72 n "na Aedic	plet	(Specify only highest g	rade completed)	(Give	kind of work done of NOT use retired	during most d)	of work	ing	b. Rind of busine	ss/mustry
212	d with giene er tha the h	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2 years	Reg	gistered 1	Nurse		İ	Medica	al al
b	al Hygen of the control of the contr	BeC	17. Father's Name (First, Middle, Lat	st)			18. Mothe	r's Name	(First, Middle, Ma	iden Surname)	
Maryland	ould b Ment arked aric e	Lo.		1more			Heler			atzer	
Jar	l 2 sh n and ris m		19a. Informant's Name/Relationship	(Type. Print)		ng Address (Street					e, Zip Code)
	1 and Health em 27 ther t		John Hutson 20a. Method of Disposition	(SON)	5 Air	tree Road	d Tow	son,	Marylan	d 21286 c. Location - City	or Town Ptoto
altimore,	Pages nent of I ant: If ite ury or o		1 X Burial 2 ☐ Cremation 3	Hemoval from State		sition (Name of matory or other place	1			•	<i>'</i>
ᆵ	artme ortani Injury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		kwood	Cemetery	ss of Facilit	4-1	1 - 07 Ba	ltimore.	, Maryland
Ba	permi Depar Impo any Ir		Gleon OF	011 2100	N	Name and Addres Litchell-V 6500 Yorl	Wiedet	feld	Funeral	Home, Ir	nc. nd 21212
3			23a. Part1. Enter the disease or co shock, or heart failure. List on	mplications that caused the death					altimore, or respiratory arres	<u>MaryLar</u> t,	Approximate
	Physician		Immediate Cause (Final disease or condition	PNEUMONTA							Interval Between Onset and Death
1	/Medical		resulting in death)	Due to (or as a consequ	ence of):						
B	Examiner		Sequentially list conditions,	b							
(b)	Si so	ine	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):						
1	xecuted and Il-transit	xaminer	cause (Disease or Injury that initiated events resulting in death) Last	c Due to (or as a consequ	ance of):						
,00	o ⊆.⊵	ш		Due to (or as a consequ	ence or).						
68760	ficate g phys is the	edic		d			_				
Вох	eath certificate be e attending physician for use as the buria	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar		1 —				23d. Date of	delivery
	The law requires that the death certificate be the has been signed by the attending physicianage 2 should be detached for use as the but	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 📉 No	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de]Ectopic pregnancy] Other <i>(specify)</i>	'	_		Month	Day Year
P.0	that the de led by the a detached	h S	9 Unknown	9∐Unknown					4		
	res tha signed be det	ρ	Part II. Other significant conditions	contributing to death but not resul	Iting in the u	nderlying cause give	en in Part I.				e to the cause of death?
000	w requin been si should I	Completed							1 ☐ Yes	2 No 3	Probably 4x1Unknown
Records,	has b	np(24a. Was an autopsy	prior	autopsy findings available to completion of cause of
a									performe 1□ Yes 2	d? death INo 1⊟Y	'es 2 □ No
Vital	Attending Physician: The r death. ector: After this certificate h. by the funeral director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital:	- D/Outration	t 3 DOA Othe	0.81		(Check only one)		
0	₽ ∓ <u>₽</u>	-0	27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of		7 1110		ne 5 ∐ Residend 28d. Describe how		pecify) HOSPICE
<u>o</u>	nding ith. r: After e funer	탏	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □ N				
Division or	Hospital or Attending 24 hours after death. Funeral Director: After ttely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not determine		me, farm, str	eet, factory, office		1	28f. Location (Stree City or Town, S		Rural Route Number,
	Ital o	Ş									- 1
	Hosp 24 hou Fune tely fill	<u>ca</u>	(Check only 2 Medical Exa	hysician: To the best of my know miner: On the basis of examinati	vledge, death ion and/or in	occurred at the ting estigation, in my o	ne, date and pinion, deat	d place, th occurr	and due to the cau ed at the time, date	se(s) and manner and place, and o	as stated. due to the cause(s)
	To the Hospital or within 24 hours after To the Funeral Dir. completely filled in I	Medical	29b. Signature and title of certifier	and manner stated.		29c. License				. Date signed (Mo	
	£ ≥ ₽ 8		and and proording)		D	h?	72		[1/ 9 /	10 7
•	*	+	30. Name and address of person who	completed cause of death (Itom	23a) (Type	Print)	1)	14		7/1/	
	10		DR. TARIO MAHMO			•	TIMONT	UM.	MD 21093		
~	© Sta	е	31. Date filed (Month, Day, Year)	32 Registrar's Signatu	ure						
	Registra	ar	APR 1 1 20	107 Steries &	STE	32.8					

			1 - For State Ragistrar	State of	f Marylan	•	artment of Hertificate of L		nd M		iene eg. No.	007	Annual company of the	05
	Dhusisi		1. Decedent's Name (First, Middle, La	ast)						2. Date of Deat Month	h Day	Year	3. Time of	Death
us Inc	Physici /Medic	-	James Weldon Jo	hnson						April	10_	2007	9:42	AM
	Examin	er	4a. Facility Name (If not institution, gi	ve street and nur	mber)		4b. City, Town, or		Death		4c. Co	unty of Deeth		
	4A.	₫,	Hanson Home Care		- 4		Balti ff Under 1 Year	If Under 2	A Hrs	D. Data of Birth		O Birth	alana (Ctoto o	e Famina
	Funeral			Sex 15⊈M 2□F	7. Age (In yrs.	iast birthday) Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day,		Cou	olace (Stete o	1 rareign
	Director		218-14-0259 Usual Residence of Decedent	Λ	82					07/06/1	924	Mary	Land	
	land ow		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation						10d. fnside Ci	ty Limits
	f sh	ō	Maryland			Bali	timore						1X Yes	2 🗌 No
	ith the Marylan or 28a-f show	rec	10e. Street and Number				10f. Zip Code			1	0g. Citizer	n of What Cou	ntry?	
	3a o	D	1722 East 31St.	Street			21	218			U.S	.A.		
	ms 2	Funeral Directo	11. Maritaf Status		edent Ever in U	.S. 13.	Was Decedent of His If Yes, specify Cubar		gin? (Spe	city Yes or No-	14.	Race - Ameri Black, White,		
9	or Its	Fu	1 XNever Married 2 ☐ Married	1X1Yes If Yes, Giv	2 No 34		1 ☐ Yes 2 ☐ No	Specify:	, , , , , , ,		S			
21215-0036	within 72 hours after death with the Maryland ene. than *netural', or items 23s or 28s-f show ha Madical Examine must be multind at	d by	3 Widowed 4 Divorced	Year or D	/e 194 ates: 194	6							ack	
5	72 h	Completed	15. Decedent's E (Specify only highest g			(Give	dent's Usuaf Occupa kind of work done d	luring most	ol worki		16b. Kind	of Business/Ir	idusfry	
12	han han	mp	Elementary/Secondary (0-12)	College (1	1-4or 5+)		DO NOT use retired,	,			m		مد ٿيا.	
	Hygie Hygie other t		12 17. Father's Name (First, Middle, Las	()		Truc	ck Driver	18 Mother	r's Name	(First, Middle.		nsporta mame) II	known	
Maryland	be fi	Be	17. Fallier S Harris (First, Middle, Las	Unknow	'n					, , , , , , , , , , , , , , , , , , , ,			IVIOMII	
Ž	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shov other treumatic event, the Medical Exprendent rusal be notified at	P	19a. Informant's Name/Relationship	(Type Print)		19h Maili	ng Address (Street a	ind Numbe	r or Rum	l Route Number	r. City or T	own. State. Zi	o Code)	
Ma	nd 2 shall alth and 27 is m r treum						East 31st							218
	1 and Health Iem 27 other tr		Adolph Hanson /	Caregive	20b. F	Place of Dispo	osition (Name of					tion - City or T		
100	Peges nent of int: if it iry or o		1 ☐ Burial 2 ☐ Cremation 3		State		matory or other place		/	. /2007	224	- 14:11.	Marin	d
Baltimore,			4 ☐ Donation 5 ☐ Other (Special Services Lice		Gar	rrison	Forest Ce	s of Facility)4/18 / ml-	3/200/ C	wing.	S MILLS	MALY	Taim
Ba	permit. Departrimports any inj		2. Marion of American	C. 1		1	2. Name and Addres	uate.	' The	Derric	KC.	Jones 1	F/H, P	.A.
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	inplications that	aused the deat							· mary	Approximat Interval Bet	te tween
9.	Physician		Immediate Cause (Final disease or condition		ua mous		concer o						Onset and	Death
	/Medical	8	resulting in death)		(or as a conseq	quence of):	· caree			1				
	Examiner	4	Sequentially list conditions,	b										
	D =	ner	if any, leading to immediate cause. Enter Underlying	Due to	(or as a consec	quarice of).						Ť		
V	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	,	0							_	
Ö	e exe		1950iting in death) Last	Due to	(or as a conseq	quence of):								
8760,<	ate b hysic the b	lical	•	d										
Ö	e as t	Physician/Med	IF FEMALE:	00- 15					-					
Вох	leath certifi attending I for use as	lan/	23b. Was decedent pregnant in the past 12 months?	1☐Live b	tcome of pregna pirth 2 ☐ Feta	aldeath 3	Ectopic pregnancy				23	 d. Date of deliver Month 	,	Year
o.	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregr 9□Unkn	nant at time of o own	death 5	Other (specify)							
<u>С</u>	res that the de signed by the a be detached f		Part II. Other significant conditions	confributing to d	eath but not res	sulting in the I	inderlying cause give	en in Part I.		23e. Did to	bacco use	contribute to	the cause of o	death?
JS,	ires ti signe	ð	7 arms originated contains	outiliousing to a	04.11.00	January III III I				1 🖫 Ý	es 2 🗆	No 3□Pro	bably 4 🗍	Unknown
Records,	The law requires ate has been sign page 2 should be	Completed					-							
ec	e law has b	npi								24a. Was a autop: perfor	sy	24b. Were aut prior to c death?	ompletion of a	cause of
<u> </u>		S									2 WNo	1 ☐ Yes	2 🗆 No	
/ita	Physician: 1 r this certifical ral director, p	Be	25. Was case referred to medical examiner?	Hospital:			Othe			n (Check only or		,	nome	Cone
of.	Physi this al dir	မ	1 Yes 2 No	28a. Date		ER/Outpatie				me 5 Resid			ify) c	enter
n N	ding P h. After funer	on	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	(Mon	th, Day Yeer)	Injury	Work	k? Yes 2 ∐ I		zou. Describe ii	OW III I I I I	Socurrou		
Sic	Attending r death.	icat	2 Accident investigate 3 Suicide 6 Could not	be ass Bloom	of Injury - At h	nome farm st	reet, factory, office			28f. Location (S	treet and	Number or Ru	ral Route Nun	nber.
Division of Vital	를 들 를 들	Certification;	4 Homicide determine	d 200. Place build	ing, etc. (Speci	fy)	reet, factory, office			City or Tow				
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 ☑ Certifying 1	hysician: To the	e best of my kno	owledge, dea	th occurred at the tim	ne, date an	d place,	and due to the d	ause(s) a	nd manner as	stated.	e)
	in 24 in 24 he Fu	ledical	one)		ner stated.	ation and/or ii	nvestigation, in my of		ar occur					2/
	vith To t	Σ	29b. Signature and title of certifier	12.1			29c. License		a	1	4	signed (Month	, uay, Year)	
,			146-1	NI			03	963	1		7-10	0.07		
	211		30. Name and address of person wh	o completed caus				, 1 .		QW s		701		
	7		Ann Simen	ND Z	2 S. G	reene	574 B	Jalti.	WOK	S WD		1201		
	Sta Regist	ate rar	31. Date filed (Month. Day, Year)	107	Registrar's Sign	aiure								

ORIGINAL

DHMH 17 Rev 1/2001

			For State Registrar	State	of Maryland / Dep Ce	ertificate of L			ene o	07	1406
			1. Decedent's Name (First, Middl	e, Last)				2. Date of Death			3. Time of Death
	Physici		Mary Katherine	Tacobsen				Month 04	08 2	Year 2007	8:02 AM M
	/Medi Examir		4a. Facility Name (If not institution		imber)	4b. City, Town, or	Location of Death	UT	4c. Count		O.UZ API
			7403 Goettner	Road		Kingsvi	ille		Bal	timor	`e
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		9. Birtho	lace (State or Foreign
	Director		214-22-5841	1□M 2 ∑ F	79 Yrs.	Months Days	Hours Min.	07/28/1	Year)	Cour	vland
	D		Usual Residence of Decedent					01/20/	721	TICL	y taria
	nylan how		10a. State 10b. County		10c. City, Town or L	ocation.				1	0d. Inside City Limits
	Ma-f s	io	MD Balt	imore	Kingsvil	lle					1 ☐ Yes 2X No
	h the	ě	10e. Street and Number	-		10f. Zip Code		10	g. Citizen of	What Cour	itry?
	death with the Maryland rms 23a or 28a-f show ris ust be natified at	a D	7403 Goettner	Road		21087			U.S.A		
	dea	Funeral Director	t 1. Marital Status		edent Ever in U.S. 13.	Was Decedent of His	spanic Origin? (Sp	ecify Yes or No-	14. Ra	ce - Americ	
9	or Ite	3	1 Never Married 2 Marr	ied 1 ☐ Yes	2 X No	If Yes, specify Cubar		Alcan, etc.)		ck, White,	
8	Surs.	l by	3X Widowed 4 □ Divorced	If Yes, Gi Year or D	Dates:	1 ☐ Yes 2 No	Specify:		Specia	^{b:} Whi	te
5-0036	72 h	Completed	15. Deceden	t's Education st grade completed)	16a. Dece	edent's Usual Occupa s kind of work done d	ition	ing 1	6b. Kind of E	Business/Ind	dustry
2121	thin	ηbje	Elementary/Secondary (0-12)	College (life	DO NOT use retired))	mig			
2	or the	ő	9		Hon	nemaker			Own I	Home	
p	al Hy	Be (17. Father's Name (First, Middle,	Last)			18. Mother's Name	e (First, Middle, M	aiden Sumai	ne)	
la	Ment Went	ပ္	Ambrose Dougla	S			Jennett	e Schles	singe	r	
Maryland	2 sho and is my	1	19a. Informant's Name/Relations	hip (Type, Print)	19b. Mail	ing Address (Street a	nd Number or Rura	al Route Number,	City or Town	, State, Zip	Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show with injury or other treumatic event, the Marical Examiner is usine to nutified at ance.		Charlene M. Ya	tes (ne	eice) 7403	Goettner	Road - I	Kingsvill	e, Mai	rylan	d 21087
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	2 🗆 🗆 🗆	20b. Place of Disp	osition (Name of matory or other place			Dc. Location		
Ĕ	Pag nent int: h		4 Donation 5 Other (S	pecify) Crynt		Mem. Park	04/1	1/2007	Raltim	ore M	aruland
a	parte porte		21. Signature of Funeral Service								Home, P.A.
œ	Depa Impo eny ir	ij i	1 C. A.	Kasa		750 Belai:					
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the death. Do not en						Approximate Interval Between
	Physician		Immediate Cause (Final	only one sadso on	can in	hotain	410 T) I known	unil	1,00	Onset and Death
4	/Medical		disease or condition resulting in death)	a. Due to	(or as a consequence of):	APIYVIC	TIVE	WINCH	JY L	2/30	alk
	Examiner			ctr.	101000	addi	· fon		()		-
<u> </u>	1	e	Sequentially list conditions, if any, leading to immediate	b. Dae to	(or as a consequence of):	er a au	160				
di,	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	S .							
ິ	exector and and rial-tr	Exa	resulting in death) Last	Due to	(or as a consequence of):						
68760,	icate be executed physician and s the burial-transit	dical		L d.							
89	ifficat g phy as th			-		1					
Вох	The law requires that the death certif site has been signed by the attending page 2 should be detached for use a.	Physician/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnancy	-			23d. Da	ite of delive	N'VIT
m	death a atte	icia	in the past 12 months?		oirth 2□Fetal death 3[nant at time of death 5[□Ectopic pregnancy □ Other (specify)				onth	Day Year
P.0	tt the de by the tached	ys	9 ☐ Unknown	9□ Unkn	own						
σ.	that		Part II. Other significant condition	ns contributing to d	eath but not resulting in the u	ınderlying cause giver	n in Part I.	23e. Did toba	cco use con	tribute to th	e cause of death?
gp.	uires rign ld be	d by	xecurre.	wt c	neuma	men		1 ☐ Yes	2 No	3 Prob	ably 4 Unknown
of Vital Records,	w requ	Completed	Branchia	like	abliton			04. 146			/ `
3e	has has	E E	0,0110110	1113	UDITIER	CIVIS		24a. Was an autopsy performs	24b.	were autor prior to cor death?	osy findings available appletion of cause of
a	n: The licate har, page									1 Yes	2□ No
₹	Physician: rthis certifice ral director, j	Be	25. Was case referred to medical examiner?	Hospital:		T .	26. Place of Death				
ō	Phys this aldir	2	1 Yes 2 No	יטי	Inpatient 2 ER/Outpatie		4 Nursing Hor	me 5 Residen)
L C	5 9 9	Certification;	1) Natural 5 ☐ Pendin-	9	of Injury th, Day Year) 28b. Time of Injury	Work		28d. Describe how	injury occur	red	
Division	Attending or death. ector: After by the fune	cat	2 Accident investig 3 Suicide 6 Could r	ot be			es 2 No				
⋛	fter of All	E	4 Homicide determ	ned 286. Place	of Injury - At home, farm, st ng, etc. <i>(Specify)</i>	reet, factory, office	1	 Location (Stre City or Town, 	et and Numb State)	er or Rura	Route Number,
	Hospital or 24 hours efte Funeral Dir tely filled in		00 0 10								
	To the Hospital or Attendi within 24 hours eller death. To the Funerst Director: A completely filled in by the fo	edical	29a. Certifier 1 Certifyin (Check only one) 2 Medical I	examiner: On the b	best of my knowledge, deat asis of examination and/or in	h conumed at the time exestigation, in my opi	e date and place, a inion, death occurre	and due to the cau ed at the time, dat	se(s) and mi e and place.	anner as st	ated. the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and man	ner stated.	29c. License					
	F 2 5 8		255. Digitature and the or certifier	,)	1 h ? nt	- AAT	- nolls	7 29°	I. Date signe	u (мопта, 1	Day, rear)
,			1 ner	ev.		14/1	JUUYOT.	DO	_T/	10/	100 +
	12		30. Name and address of person	who completed caus	se of death (Item 23a) (Type,	Print	15151	To The	10	10	HALMO
	,		21 Date filed (Marth 2: V	IV\	e T		31)	CV	CVXI		White the
	Sta	te	31. Date filed (Month Day: Year)	2007	egistrar's Signature						

Laxed to ME

			For State Registrar	Please	State of		nd / Depa	artmei	nt of H			1			11407
	DI		1. Decedent's Name (F	First, Middle, Last)							Date of De	ath Day	Year	3. Time of Death
	Physici /Medio		Way.	ne -	Jacob	son		,				April	7	2007	10:50 M
	Examin		4a. Facility Name (My) of 11413 Glen	Arm Roa	ad				(Location of	Arm		Ва	County of Death	
	Funeral Director		5. Social Security Num 520-16-373	19 11	x 85M 2□F	7. Age (In yrs. 84	. last birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	Min.	Date of Bil 05/10	*/ 1°9 ′2	9. Birth	place (State or Foreign intry)
	and *		Usual Residence of De 10a. State 10	Ob. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	Manyi f eho	ō	MD	Baltimor	e	Gl	en Arm								1 ☐ Yes 2 ☐ No
	with the	i Director	10e. Street and Number 11413 Glen		ıd				ip Code 057				10g. Citi USA	zen of What Cou	intry?
036	d within 72 hours after death with the Maryland liene. r then "naturel", or Items 23a or 28a-f ehow the Medical Examinar must be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 3 ☑ ₩7idowed 4 [_	12. Was Deced Armed For 1 (24Yes 2) If Yes, Give Year or Da	ces? 2 ∐ No			_	spanic Orig n, Mexican Specify:	gin? (Spec , Puerto Ri	fy Yes or No can, etc.))-	14. Race - Amer Black, White Specify: Whi	, etc.
1215-0	within 72 horens. ene. then "natur	Completed	15 (Specify Elementary/Seconda	5. Decedent's Edu only highest grad ary (0-12)	cation		16a. Dece (Give life. Physi	kind of w	ork done d use retired	luring most	of working	7		nd of Business/l vate Pra	
Baltimore, Maryland 21215-0036	be filed htal Hyg ad othe event,	To Be Co	17. Father's Name (Fin Arthur Ja	st, Middle, Last) acobson							r's Name (First, Middle	, Maiden	Sumame)	
Mary	ges 1 and 2 should to the lith and Ment If Item 27 is marked or other treumatic e		19a. Informant's Name Eric Jacob		γρe, Print)									r Town, State, Z. York, NY	
more,	Pages 1 annent of He Int: If Item Iny or othe		20a. Method of Dispos 1 Deurial 2 C 4 Donation 5	Cremation 3 □F			Place of Dispo cemetery, crei lly Hi	matory or	other plac	al Ga		5r 11		cation - City or 1	own, State , Maryland
Balti	permit. Page Department Important: If any Injury or ance.		21. Signature of Funer	ral Service Licens		40141	1 -					Altern			yland 21286-
	Physician		23a. Part1. Enfer the oshock, or heart fa Immediate Cause (Fin disease or condition	ailure. List only o	ne cause on ea	ch line									Approximate Interval Between Onset and Death
\$,0928	Medical Examiner physicien and the privilensity the privilensity the privilensity that t	dical Examiner	Sequentially list condition and the condition of the cause. Enter Underlyth Cause (Disease or injurat initiated events resulting in death) Las		c	or as a conse	quence of):	Ca	s Di	ony	opa.	thy			
.O. Box 68	The law requires thet the death certificate to the has been signed by the attending physic page 2 should be detached for use as the bearened.	Physician/Medi	IF FEMALE: 23b. Was decedent pr in the past 12 mc 1 □ Yes 2 □ N 9 □ Unknown	onths?		nth 2 ∏ Fet antattime of	al death 3	□Ectopic □ Other (s	pregnancy specify)					23d. Date of deli Month	very Day Year
<u>α</u>	uires thet n signed b ild be deta	Ď	Part II. Other significa	Fibr	illation	1		nderlying	cause give	en in Part I.					the cause of death?
Division of Vital Records,	The faw requirete has been sipage 2 should	Completed	Mitral	Ins	uffic	ence						24a. Was auto perfe		death?	opsy findings available ompletion of cause of 2 □ No
ita	ician: Th certificate rector, pag	Be	25. Was case referred examiner?	Lto medical							of Death (Check only	опе)		
n of V	ng Physician: ifter this certifical	ဥ	1 ☐ Yes 2 € No 27. Mannar of Death	5 ☐ Pending	28a. Date o		28b. Time o	f	28c. Injun Worl	/ at	28	e 5 Res		S □Other (Spec y occurred	ify)
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_	Hospital 24 hours a Funeral letely filled	ledical Ce		Certifying Phy Medical Exam		sis of examin									
	To the within 2 To the Complet	Me	29b. Signature and title	e of certifier				2	9c. Licens	e number			29d. Dat	e signed (Month	, Day, Year)
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	10 X1		30. Name and address	N 0/		of death (Ite	om 23a) (Type,	Print)		arte.					21212
	Sta , Registi		31. Date filed (Month,	Day, Year) PR 1 1 2		gistrar's Sign	nature	and the	9						

ORIGINAL

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland	•	ment of He			jienę (eg. No.	07	11408
	Physici /Medic		1. Decedent's Name (First, Middle, Last) BERTHA	JOR	DA,	V		2. Date of Dea Month PRIL	Day	Year 2007	3. Time of Death
20	Examin Funeral Director		4a. Facility Name (If not institution, give str Rock Glen Nursi 5. Social Security Number 6. Sex		st birthday)	Balt	imore If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Yeer)	A 9. Birthpl	• •
	0		217-24-8146 Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Locat	ion		07 27	19_	10	VA
;	n the Mary r 28a-1 sh r coliffed	Director	MD NA 10e. Street and Number	Bal	ltimor	'e 10f. Zip Code		1	l0g. Citizen	of What Count	Y□Yes 2□No
036	should be liled within 72 hours atter death with the Maryland and Mental Hygiene. The Maryland marked other than "natural" or items 23a or 28a-f show marked other than "natural" or items 23a or 28a-f show imatic event, it a Medical Examiner must be notified at	by Funeral	5226 Hillwell Rd 11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	Dad . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:				pecify Yes or No- Rican, etc.)	14. F	J_S_A_Race - America Black, White, e	
7	nthin 72 house.	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)		(Give kin life. DO	NOT use retired)	uring most of worl	king		f Business/Ind	
nd 21	I be filed within ntal Hygiene. ed other than '	Be	11th grade 17. Father's Name (First, Middle, Last)	na	Don	estic	18. Mother's Nam	e (First, Middle,	Maiden Sun	rivate name)	
lary	2 a a a	2	William Pemberto 19a. Informant's Name/Relationship (Type	e, Print)			nd Number or Ru	Holme	r, City or To		
ď.	ges t an t of Heal if Item 2 or other		Earl B. Jordon-S 20a. Method of Disposition 1 \(\mathbb{Z}\)Burial 2 \(\mathbb{C}\)Cremation 3 \(\mathbb{R}\)ei	20b. Plac	ce of Disposition of the company of	on (Name of ory or other place)	Balti	20c. Locatio	on - City or To	
Baltin	permil. Peg Department Important: I any injury o once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Nomoon	Mar	ame and Address	West				Co, Md
F	Physician		23a. Part Enter the disease, or complica shock or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the deeth.				Balti or respiratory arr		Ма	21215 Approximate Interval Between Onset and Death
# 1 m	Centilicate be executed ding physicien and lase as the burial-transit	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a conseque	aly nce of): I ten	Arle	y Di	sla	le		
n i	death e atter ed for u	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠ No 9 □ Unknown	e. If yes, outcome of pregnance 1 Live birth 2 Fetal de 4 Pregnant at time of dea 9 Unknown	eath 3□Ec	topic pregnancy her (specify)				Date of deliver Month	y Day Year
rds, P.	quires that n signed b uld be deta	by	Part II. Other significant conditions control	ibuting to death but not resulti	ing in the unde	rlying cause giver	n in Part I.		bacco use c es 2 🏹 No		e cause of death?
	ysician: The law requires that the is certificate has Leen signed by the director, page 2 should be detache	e Completed	25. Was case referred to medical						med? 2 No	prior to con death?	sy findings available apletion of cause of
on of Vil	After th	ToB	examiner? 1 Yes 2 No 27 Manner of Death 1 Natural 5 Pending		P/Outpatient 8b. Time of Injury	3 DOA Other	4 X Nursing H	th (Check only or ome 5 Reside 28d. Describe he	ence 6 🗆)
Division of	al or Attendi s after death. It Director: A od in by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street			28f. Location (S City or Town		mber or Rural	Route Number,
	o the Hospital or within 24 hours afte To the Funerel Dir completely filled in	edical (29a. Certifier (Check only one)	cian: To the best of my knowledge. On the basis of examination and manner stated.	edge, death oc n and/or inves	curred at the time tigation, in my opi	e, date and place, nion, death occur	and due to the c red at the time, d	ause(s) and ate and plac	manner as sta ce, and due to	ited. the cause(s)
,	To the complet	Me	29b. Signature and title of certifier.	ray M.D.		29c. License		1		ned (Month, E	
	U		30. Name and address of person who com	ASKARAN,	3455	Wilk	ens A	107 . Ba	chm	104/	1007
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	Carle	9					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month LOUIS KRASNODEMSKI 6:30 AM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hopkins Eldercare Plus Edgemere Baltimore Co. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 F Months Director 215-32-2623 Yrs 22,1936 Aug Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, I'm Medical Evantual tentilised at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6506 Hartwait Avenue 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1☐ Yes 2√2 No Specify Specify: White 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 N/AMechanic Bowling Alley 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Joseph Krasnodemski Madeline Welsch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Eaton - Sister-in-Law 7958 Kavanagh RD. Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 4-11-07 Overlea, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Ave. Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician CONGES MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit death certificate be execu Due to (or as a consequence of): the attending physician Physician/Medicai use as the IF FEMALE: KRASNODEMSKI, LOUIS 23c. If yes, out*co*me of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 □ Pregnant at time of death 5 Other (specify) 9 🗆 Unknown been signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Division of Vina, 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; within 24 hours after death. To the Funeral Director: After 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 Tyes 2 No 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D006217 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore We MI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

_			1 - For State Registrar	State of M	laryland / Depa <i>Ce</i>	artment of He			ene	07	
1	Physic	ian	1. Decedent's Name (First, Middle, L	•				2. Date of Death Month		Voor	3. Time of Death
	/Medi		James	Bon		Law		April 5	,_2007	Year	10:10 P M
1	Exami	ner	4a. Facility Name (If not institution, g			4b. City, Town, or L			4c. County		
			3701 Internation 5. Social Security Number 6.				r Springs		Monte	omer	у
L	Funeral Director		181 05 7692 Usual Residence of Decedent	4 AU 00 F	ge (In yrs. last birthday) 87 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept 2,	Year) 1919	9. Birthpl Count PA	lace (State or Foreign try)
	fand wo		10a. State 10b. County		10c. City, Town or Lo	cation				10	0d. Inside City Limits
	Mary -1 eh	ğ	Maryland Montgo	merv	Silve	r Springs				1,,	1 ☐ Yes 21/201/No
	r 28a	Director	10e. Street and Number		DIIVO	10f. Zip Code		100	g. Citizen of W	/hat Count	****
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36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural", or Items 23a or 28a-f show event, tra Madical Examera must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1	No LAJTT	✓ Was Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race	- America k, White, e	an Indian,
Maryland 21215-0036	2 hot	ē	15. Decedent's E	Education	16a, Dece	dent's Usual Occupation	on	16	6b. Kind of Bu	cinace/lad	
215	within 7 ene. then 'n	Completed	(Specify only highest gill Elementary/Secondary (0-12)	rade completed) College (1-4or	(Give	kind of work done dur OO NOT use retired)	ring most of workir	ng i	D. KING OF BU	311162271110	ustry
21	e filed within al Hygiene. other then '	E	12	2		power		F	ederal	Gove	rnment
p	be filed ital Hygi of other	Be	17. Father's Name (First, Middle, Las	t)		1	8. Mother's Name				.1 IIIIEIIC
<u> </u>	Menta Menta mrked atic ev	10	John C. Law				Mar	y Ann Bo	v1e		
ar	2 sho and le ma	0. 5	19a. Informant's Name/Relationship	(Type, Print)		g Address (Street and	d Number or Aurai	Route Number, (City or Town, S		
	and ealth m 27		Laura Pompa (Da	ughter)		Baffin Ba	•	Rockvill	e, MD	20853	3
ore	of H of H		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 (TRemoval from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place)	Di	ate 20	c. Location - 0	City or Tov	vn, State
Baltimore,	permit. Peges 1 and 2 should b Department of Health and Menis Important: If Item 27 Ie marked eny injury or other traumatic e ance.		4 □Donation 5 □ Other (Spec	ify)	Lee Crem	atory Apri	16, 200		linton		
3all	permit. Depart Import eny in		21. Signature of Funeral Service Lice	ns@e	22	. Name and Address	of FacilityLee	Funeral :	Home,Iı	nc 66	33 01d
ш	405 a		MADDY			lexandria				20	735
,	Physician /Medical Examiner	ılner	23a. Pent1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Caveiu Due to (or as Due to (or as	a consequence of): turic dis	rostate ease: 10	ugs, li	ver, B			Approximate Interval Between Onset and Death 12 years
. Box 68760,	deeth certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical Examiner	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	d	a consequence of): of pregnancy 2 □ Fetal death 3 □	Ectopic pregnancy Other (specify)			23d. Date Mont		y Year
o.	at the de by the a	hys	9 ☐ Unknown	9□ Unknown							
s,	w requires that been signed to should be deta	by	Part II. Other significant conditions	contributing to death be	ut not resulting in the un	derlying cause given i	in Part I.	23e. Did tobac	co use contrib	oute to the	cause of death?
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Vitai Records,	beta 3e.2	Completed	Hyperteusion	('				24a. Was an autopsy performed	or	ere autops ior to comp ath?	sy findings available pletion of cause of
		ပို့ .	25. Was case referred to medical			_		1□ Yes 21	No 1		!□ No
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DIVISION OF	g Phys er this eral di	<u>-</u>	27. Manner of Death	28a. Date of Injur	y 28b. Time of	3□ DOA United 28c. Injury at Work?	4 Nursing Hom	d. Describe how			
<u> </u>	el or Attending F s effer death. I Director: After d in by the funera	읉	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	(Year) Injury		2 □ No		,,	•	
<u>s</u>	Atte	읕	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	289. Place of inju	ury - At home, farm, stre	et, factory, office	28	f. Location (Stree	t and Number	or Rural F	Route Number
5	s efficient	Certification;		building, etc	:. (Эрөспу)			City or Town, S	itate)		
	To the Hospital or Attenwithin 24 hours effer deat To the Funeral Director: completely filled in by the	edical	29a. Certifier Cortifying Phone 2 Medical Example 2	nysicien: To the best of niner. On the basis of and manner sta	of my knowledge, death examination and/or inve ted.	occurred at the time, ostigation, in my opinio	date and place, an	d due to the caus at the time, date	e(s) and mann and place, an	ner as stat d due to th	ed. he cause(s)
)	To the To the Comp.	M	29b. Signature and title of certifier	empale	- ms	29c. License nu D 0 4 2	o 49	29d.	Date signed ((Month, Da	1y, Year)
١	12+1		30. Name and address of person who Hair G. CHA W	completed cause of de	eath (Item 23a) (Type, P	() pper	049 Man(b	oro_N	10.	20	772
	Stat		31. Date filed (Month, Day, Year)	32. Registra	r's Signature						
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DHMH 17 Rev 1/2001

State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Simon V.

31. Date filed (Month, Day, Year)

D24276

Scalia, MD 2801 Hudson St. Baltimore, MD 21224

April 10, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** PM MARY L. LOWRIMORE APRIL 2007 1600 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 610 GLENVIEW AVE. SW GLEN BURNIE ANNE ARUNDEL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Sex 1 M 2 F XX **Funeral** Months Days Hours Director DEC 30, 1955 214.76.0846 MD 51 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD ANNE ARUNDEL **GLEN BURNIE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 GLENVIEW AVE. SW 21061 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No Specify. 3 4XX Divorced 3 Widowed WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the 12 HOME MAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM THOMAS MCPHAIL 2 VIOLA E. GURGANUS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury ROBERT WILLIAM LOWRIMORE SON 309 GREENWOOD RD. LINTHICUM, MD. 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) BAYVIEW CREMATORY INC 4.16.2007 BALTIMORE, MD 21. Signature i Funcial Service 22. Name and Address of Facility FINK FUNERAL HOME, P.A. . GREGORY FINK M01148 426 CRAIN HWY S GLEN BURNIE, MD 21061 23a. Part . Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or andition resulting in eath) **Physician** /Medical Examiner Sequentially list conditions, Due to for as a constituence of Examine if any leading to immedi-cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Physician/Medical the. as 1 IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe death? 1 ☐ Yes 2 No 2 No 1□ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one Other: 4 Nursing Home 2 NO 1 Tes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Pesidence 6 ☐Other (Specify) 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Injury 5 Pending 1 Yes 2 No investigation 2 Accident

Box 68760. death certificate be P.O. Division or Vital Records, Hospital or Attendi 4 hours after death. Funeral Director: A

72 hours after

should be filed within 7.
Ind Mental Hygiene.

1 and 2 should be fil Health and Mental H em 27 Is marked otl

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attending physician

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certificate

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After

6 Could not be determined

Year)

APR 11

3 Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

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31. Date filed (Month, Day,

30. Name and address of person who

death.

24 hours a e Funeral I Hospital

within 24

Maryland 21215-0036

altimore,

10 State Registrar

DHMH 17 Rev 1/2001

ertifyin.

n: To t best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintain as scales.

2 Medical r: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and anner stated.

29c. License numbe

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

use of death (Item 23a) (Type, Print)

GLER gistrar's Signature

Jerry D Langley		S I - For State Registrar	tate of Marylan		irtment c <i>tificate c</i>		and N	/lental H		Reg. No. 20	107 1:41		
Physiciai Medical Examin	n/	Decedent's Name (First, Midd	·						2. Date of Dea Month_	ath Day Year	3. Time of Death 0003 hrs		
iviedicai Examini		Jerry 4a. Facility Name (if not instituti	D .	per)		Lang		ation of Dear	April 5, 20	4c. County of			
		923 North Bentalou S	Street	,		Baltimo				,			
Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. la	ast birthday)	If Under		Under 24H			Birthplace (State or Foreign		
Director	-	219-04-5207	1 X M 2 F	39	Yı	Months s.	Days I	Hours Mi	ⁿ 02 1	.7 68	Country) NC		
ú	- 1	Usual Residence of Decedent 10a. State 10b. County		10c, City,	Town or Loca	ation					10d. Inside City Limits		
show a	_	MD NA	A	Ва	altimo	ore					1 X Yes 2 No		
1arylar 28a-f	Director	10e. Street and Number				10f. Zip C	ode		1	10g. Citizen of Wha	at Country?		
h the N 3a or	₫	923 North Be	entalou S	treet			212	16		U.S	S.A.		
tems 2	Funeral	11. Marital Status 1 X Never Married 2 N	12. Was Deced Armed Forc	es?		 Was Decedent of Hispanic Origin? (Specify Yes or I If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 					No- 14. Race - American Indian, Black, White, etc.		
fter der ", or i			1 Yes	2 X No	1	Yes 2X	No sp	ecify:		Specify:	Black		
ours a atural	g Q	15. Decedent's Education (Spe		completed)	16a. Decede	nt's Usual Do				16b. Kind of Bus	iness/Industry		
36 in 72 h	pleted	Elementary/Secondary (0-12)) College (1-4 4yrs	or 5+)	Ü	rict			ui ed)	Car	Rental		
d with	- ∟	17. Father's Name (First, Middle			5150				ne (First, Middle,	Maiden Surname)			
21215-0036 Jud be filed within 7 Mental Hygiene marked other than	å ,	Jerry Langle	У				Da	rlene	e Battl	.e			
		19a. Informant's Name/Relation		r	19b. Mailir 923	ng Address North	(Street and Ben	d Number or talo:	Rural Route Nu	mber, City or Town	n, State, Zip Code) Co, Md 21216		
Baltimore, MD remit. Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumaninjury or other trauman.		20a. Method of Disposition		20b. F	Place of Dispo crematory or o	sition (Name			Date		City or Town, State		
MOF Pages eent of int: If		1 Burial 2 Crematio 4 Donation 5 Other S					l Pa	rk 4,	/12/07	Randall	lstown, MD		
Salti ermit. epartm nports njury o	4	onature of Funeral Service		'		Name and Adarch							
Physician	4	23a. Part I. Enter the disease, o	arumplications that cau	sed the death	14	300 W	abas	h Ave	e, Balt	imore,	Md 21215		
/Medical		failure. List only one cause Immediate Cause (Final disease	e on e ch ine.						syndrame (Between Onset and Death		
Examiner		or condition resulting in death)	Due to (or as a co						(
	اةِ	Sequentially list conditions, if any, leading to immediate	b Due to (or as a co	onsequence of	f):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	onsequence of	f):								
ecuted and transit	<u>~</u>		d										
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	edical	X UNPENDED	#23a,27,	perME, g	867,5/3/	'07 TT							
876 tificate		IF FEMALE: 23b. Was decedent pregnant in t past 12 months?	23c. If yes, out	tcome of pregr	nancy	etal death	3E	ctopic pregr	nancy	23d. Date of o Month	delivery Day Year		
, P.O. Box 6876 ires that the death certificate signed by the attending phy be detached for use as the	Physician/N		-1	nt at time of de	ath 5 C	ther (Specify	v)						
D. B. the de by the by the iched f	퉏	Part II. Other significant condi	9 Unknow	1111-0-1-1-1	esulting in the	underlying c	ause given	n in Part I.	23e. Did t	obacco use contrib	oute to the cause of death?		
P.C es that es that be deta	ā P								1Ye	es 2 No 3	Probably 4 V Unknown		
Vital Records, ysician: The law requii	ompleted								24a. Was		ere autopsy findings available for to completion of cause of		
tal Records cian: The law requi certificate has been ector, page 2 should	d Wo	-								ormed? de 2 ✓ No 1	eath? Yes 2 No		
ian: 1	Bec	25. Was case referred to medic examiner?				26		Death (Chec					
f Vif Physic er this	리	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inp	patient 2	ER/Outpatier 28b. Time of		A Othe		ing Home 5	Residence 6 v			
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the ras after death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	Certification:	1 X Notural	(Month, D	lay,Year)	200. 11110 0		1 Yes		200. 5000.150	non injury occurs			
/iSic	ficat		estigation 28e. Place of	of Injury - At ho	ome, farm, str	eet, factory, c	ffice buildi	ing, etc.	28f. Location or Town,		r or Rural Route Number, City		
Dive Hospital of 24 hours af Funeral Detector filled	Set	4 Homicide	ermined (Specify)						or rown,	State)			
		29a. Certifier (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of	of my knowlede examination a	ge, death occ nd/or investig	urred at the ti ation, in my o	me, date a pinion, dea	and place, ar ath occurred	nd due to the cau Lat the time, date	ise(s) and manner : and place, and du	as stated. ue to the cause(s)		
To t with Te t	Medical	29b. Signature and title of certif	and manner stat		1		License nu				ed (Month, Day, Year)		
		Test 111	181/	7			O.C.M.E	≣.		April 5, 200	7		
	-	30. Name and address of perso											
			Assistant Medical	A		nn Street,	Baltimo	ore, MD 2	1201				
Sta	ite	31. Date filed (Month, Day Year	1 2007	strar's Signatu	O A								

					delible ink. Ensure A artment of Health and i		_	
		-	For State Registrar		rtificate of Death		g. No.2 (1) 7	
Phy	sicia	n	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
/M	ledic	al	WILLIAM EBAUGH LAM		4b. City, Town, or Location of Death	April 7,		4:25 A M
Exa Fune Direc		- 14	4a. Facility Name (If not institution, give street and number GILCHRIST CENTER AT GE 5. Social Security Number 213-01-7167 6. Sex 1 M 2 F	•	Towson	8. Date of Birth (Month, Day, July 15,	Baltimore	
pu »	1000		Usual Residence of Decedent 10a, State 10b. County	10c. City, Town or Lo	ncetion			10d. Inside City Limits
Maryla f shov	ed at	ō	Maryland N/A	Balti				1X1Yes 2 □ No
r 28a-	non	Director	10e. Street and Number	Darci	10f. Zip Code	10	g. Citizen of What Cou	untry?
th wit	nst De	밀	15 Devon Hill Road		21210		USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show	xaminer m	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	at Ever in U.S. 13, 13, 13, 13, 13, 13, 13, 13, 13, 13,	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 XNo Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
72 hou	lical	ed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation	kina 1	6b. Kind of Business/l	ndustry
vithin the.	е мес	Completed	Elementary/Secondary (0-12) College (1-4c	r 5+) _	kind of work done during most of wor DO NOT use retired) esident	9	Packing	Company
filed v Hygie	ar, m		17. Father's Name (First, Middle, Last)	s Pr		ne (First, Middle, M		Company
lid be lental ked o	ic eve	To Be	William Ebaugh Lamble, S	r.	Anne	Rittenho	use	
2 shou	anma		19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street and Number or Ru	ral Route Number,	City or Town, State, Z	ip Code)
and seath	ner ne	1		(Wife) 15 Do	evon Hill Drive,			
ages 1 nt of H	0 0		20a. Method of Disposition 1☐ Burial 2 XCremation 3 ☐ Removal from Sta	e cemetery, cre	matory or other place)		Oc. Location - City or 1	
nit. P.	e and		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	2:	unt Crematory 4/9 2. Name and Address of Facility		altimore,	,
Deg de	any ir		Martin D. Javigon		MITCHELL-WIEDEFEL 6500 Vork Bood B			
Physic			23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on eart Immediate Cause (Final disease or condition	line.	ter the mode of dying, such as cardiac	or respiratory arres	rial y land	Approximate Interval Between Onset and Death
/Medi Exami	_		resulting in death) Due to (or sometimes)	as a consequence of):				
rted	IISII	Examiner	cause. Enter Underlying Cause (Disease or injury	as a consequence of):				
te be exect	ie buriai-tra		that initiated events resulting in death) Last C. Due to (or add.	s a consequence of):				
ertificate	a as m	Medi	IF FEMALE:					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	cned for use	Physician/Medical	23b. Was decedent pregnant 1 Live birth	2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
w requires that been signed by	and be deta	اھ	Part II. Other significant conditions contributing to death	but not resulting in the u	ınderlying cause given in Part I.		acco use contribute to	`
The law reate has bee	page z sno	Completed				24a. Was an autopsy perform	prior to c	topsy findings available completion of cause of
lcian:	ector,	8	25. Was case referred to medical examiner?		Otto	th (Check only one		
Phys r this	al dir	은	1 ☐ Yes 2 ☐ No ☐ 1 ☐ Inpa 27. Manner of Death 28a. Date of It			ome 5 Resider	nce 6 Other (Spec	ity) Hospice
nding Ith.	e rune	tion	1 Natural 5 Pending (Month, 1	Day Year) Injury	of 28c. Injury at Work? M 1 Tyes 2 No	Edd. Booking No.	vinjury occurred	
tal or Atters after dea	ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building,	njury - At home, farm, st etc. <i>(Specify)</i>	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
ne Hospi n 24 hour ne Funer	pietely IIII	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the beside and manner.	of examination and/or in				
To t with	Eloo ,	Σ	29b. Signature and title of certifier Denor Black in D		29c. License number	A	d. Date signed (Month	2007
	6		30. Name and address of person who completed cause of Jason Black 65-65 North	death (Item 23a) (Type, 2 Charks S	T, Suite 209	Towson	MO 21.	204
Re	Sta gistra	_	31. Date filed (Month, Day, Year) 32 Regi	strar's Signature	ast s			,
DHMH 17 Re	ev 1/20	01			The state of the s			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 11:10 AM Eloise M. Mason 2007 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Aanes Baltmore N/A HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. 219-18-1488 Months Days Hours 1 ■ M 2 💢 F MD Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f shov must be notified at Catonsville Baltimore MD 1 ☐ Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7 Mill USA POBL Court 21228 Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on the filed and Mental Hygiene. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: Back 3 Widowed 4 ☐ Divorced 'natural", the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of University Elementary/Secondary (0-12) College (1-4or 5+) Environmental Technician Manitoend 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surnam 17. Father's Name (First, Middle, Last) Be Mitchell Butler Sarah Buck ည 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catonsville MD Department of Health a Important: If item 27 is any injury or other tra once. Nora Mickenney Court Pool /Daughter (Mill 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Owings Milb, MD Garnson Forest 04 H107 4 Donation 5 Other (Specify) 21. Signature of Funeral S 22. Name and Address of Facility Vaughn [. Greene fun oral Services e Licensee Baltimore National Pike Balto. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause og each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Vaseular **Physician** /Medical for as a consequence of): Examiner Seque tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (prias a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) has been signed by the e 2 should be detached 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown holes te 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate ha 1□ Yes Jivision or Vital 2 No Physician; 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☑ Natural 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending 1 🔲 Yes 2 🗌 No investigation Oirector: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled in 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 24 29c. License number 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) P20556 mpleted cause of death (Item 23a) (Type, Print) aton AVE Baltimore, MD filed (Month, Day, .Year) 32. Registrar's Signature State

Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours aft To the Funeral Di completely filled in

State Registrar

DBMH 17 Rev 1/2001

D

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30 Name and address of person who completed cause of death (Item 23a) (Type Print) 32. Registrar's Signature

29c. License number

Asadena

29d. Date signed (Month, Day, Year)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1 Decedent's Name (First Middle, Last) ADRIL **Physician** 2001 /Medical 4c. County of Death 4a. Facility Name (If not institution, give Examiner DICE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 ie marked other than "naturel", or Items 23a or 28e-1 ehow 10c. City, Town or Location

BACT: HORE 10d. Inside City Limits 10a. State 10b. County trsumatic event, the Madical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? 1. Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) BUSINESS 17. Father's Name (First, Middle, Last) To Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSS item 27 l 20b. Place of Disposition (Name of cemetery crematory or other 20c. Location - City or Town, State 20a. Method of Disposition Department of H Importent: If ite any injury or ot once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signifum of uneral Service licensee 23a. Part1. Enter the disease or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Endstage Physician Coodiac 1 mo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of): to the Hospitel or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 2 2 No 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No this certificate 1 Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) histic 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

32. Régistrar's Signature

f. Irwin

31. Date filed (Month, Day, Year)

056211

Hanover St.

4/8/07

Baltmore

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

and manner stated

07-02686 Frank Robert Muth	1- For State Registrar	St	oe or Print i ate of Maryla	and / Dep		t of	Health				iene	egibl	200	Baren .	
Physician/ Medical Examiner	Decedent's Name	Fra	nk R. M	uth Jr							Date of De Month pril 8, 2	Day	Year		Time of Death 1955 hrs
	4a. Facility Name (if 7125 Cunning		on, give street and no	umber)			. City, Tow Chase	vn, or Lo	ocation of			_ l	c. County of Dea Baltimore Co	ounty	
Funeral Director	5. Social Security No. 212-94-		6. Sex	7. Age (In yrs	. last birthda	y) Yrs.	If Under 1	1 Year Days	If Under Hours	1000			1/DD/YYYY) 9. E Fore 9 0	eian	
nd Show any ICe.	Usual Residence of 10a. State MD	0b. County	imore	10c. Cit	ty, Town or L		Riv	er						10	Od. Inside City Limits Yes 2 X No
h the Marylanc 3a or 28a-f sh rotified at onc			g Circl	e			10f. Zip Co	212	220			10g. Cit	tizen of What Co		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 X Never Marrie 3 Widowed		arried Armed F 1 Yes Yorced If Yes, Give Yes	2 X No		If Yes		Cuban, N	Mexican, F	n? (Specif Puerto Rica	y Yes or N an, etc.)	lo-	14. Race - Ame White, etc. Specify: Wh		
5-0036 ed within 72 hours after tygiene. other than "natural" the Medical Examine. Completed by	15. Decedent's Edu Elementary/Secon		or Dates: cify only highest gra	de completed) 1-4 or 5+)	duri	ing mos	Usual Oc t of workin	g life, D	O NOT us	nd of work se retired)	done		Kind of Busines Buildi		•
215-00: be filed with antal Hygiene riked other it ent, the Me.	17. Father's Name (Frank		Last) IUth Sr.		1 00.				Mother's	-	st, Middle J・S	Maider	n Surname)		
MD 21 32 should th and Me 127 is ma umatic ev	19a. Informant's Nar Frank &		ship (Type, Print) .la Muth	/paren								alt	City or Town, Sta Cimore	MD	21220
Baltimore, MD 21215-0036 bernit Pages I and 3 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than nijury or other traumatic event, the Medica To Be Comple	20a. Method of Disp 1 X Burial 2 4 Donation 5	Cremation Other S	pecify:		o. Place of D crematory ulane	or othe ey	Vall	еу		4/12	/07		Location - City		
Balt permit. Depart Impor injury	21. Signature Francisco Fr	1	11 0	49	- 1		onne						ve. Bal		
Physician /Medical Examiner	Immediate Cause (F	/ one caus∉ inal disease	on each line. a. Heroin	, cocain	ne and						spiratory a	rrest, sn	nock, or neart		Approximate Interval Between Onset and Death
miner	or condition resulting Sequentially list conditions leading to immorause. Enter Under	ditions, mediate lying Cause	b	a consequence											

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Division of Vital Records, P.O. Box 68760,

Exar Physician/Medical þ Completed Be Certification:

Due to (or as a consequence of): events resulting in death) Last #1.perME,g867,5/3/07TT 7,28a-f, perME, g866,4 X UNPENDED X /26/07 TT IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Year Fetal death 3 Ectopic pregnancy Month Day 1 Live birth 2 Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No ✓ Yes 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Other4 examiner? Hospital: Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 DOA 1 Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 1 Natural 1 Yes 2 X No 5 Pending Fnd 4/8/2007 Fnd 7:40 pm Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide or Town, State)
7125 Cunning found at home determined Cir. Middle River, MD Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

April 9, 2007

Patricia Aronica-Pollak MD 31. Date filed (Month, Day, Year) State

30. Name and address of person who completed cause of death (Item 23a)

\$2. Registrar's Signature

Assistant Medical Examiner

Registrar

DHMH 17 Rev 1/2001

State

Registrar

Year)

200

Registrar's Signature

			A 1.51.	rtment of Health and Menta rificate of Death	
	A 305 %		1. Decedent's Name (First, Middle, Last)		Reg. No. 3. Time of Death
	Physici		Augusta moura	O Moi	
No.	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1	LXuiiii		Future Care Chenywood	Project restriction	Baltimore
	Funeral	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. (Mo	e of Birth 9. Birthplace (State or Foreign
(E) (A)(A)	Director		219.28.1397 10 TO YIS.	08.	inth, Day, Year) Country
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ation	10d. Inside City Limits
	Maryl f sho ied ai	ō	100		1 □Yes 2 No
	the notif	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	h with		Hollo Tema Moad	21208	1154
	ems ?	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Wi	as Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rican, e	s or No- 14. Race - American Indian, etc.) Black, White, etc.
9	after or it		1 Never Married 2 Married 1 Yes 2 No	Yes 2 No Specify:	Specify: (1)
21215-0036	72 hours after death with the Maryland hatural", or items 23a or 28a-f show dical Examiner must be notified at	d by	Year or Dates:		blach
75	in 72 "na" r	Completed	(Specify only highest grade completed) (Give killife DC	nt's Usual Occupation ind of work done during most of working O NOT use retired)	16b. Kind of Business/Industry
212	d within giene.	lmo	Elementary/Secondary (0-12) College (1-4or 5+)	Care Provider	Child care
פ	be filed ntal Hygi nd other event, II	Be C	17. Father's Name (First, Middle, Last) Whrown		Middle, Maiden Surname)
Maryland	should be ind Mental marked o umatic eve	To E		Margaret N	acclain
lan	2 sho and is ma	i 17	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing	Address (Street and Numb or Rural Route	Number, City or Town, State, Zip Code)
	1 and 2 Health tem 27 i		Margaret L. Byrd / Daughter 41016	Tema Thorad Pike	Sulle MD 21208
0	Pages 1 nent of H ant: If ite ury or ot		20a. Method of Disposition 20b. Place of Disposition Burial 2 Cremation 3 Removal from State		20c. Location - City or Town, State
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify)	UCH wrat 04.12.20 Name and Addr's of Facility V Gughn	of Lauren, MID
Ba	permit. Departr Importa any Inje		21. Signature of Funeral Service Licensee		
8		1 1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter	the mode of dving, such as cardiac or respir	atory arrest. Approximate
	Physician	8 7	Immediate Cause (Final	1	Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):	suce cardio	nyopathy
	Examiner		Constantially list conditions		9
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
6	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C		
8760,	cate be executed physician and the burial-transit		bue to (or as a consequence of).		
687	ficate physis the	edical	d		
Вох	n certi	M/U	IF FEMALE: 23c. If yes, outcome pf pregnancy		23d. Date of delivery
œ.	The law requires that the death certificate has been signed by the attending I hage 2 should be detached for use as	Physician/Me	in the past 12 months? 1	ctopic pregnancy Other (specify)	Month Day Year
P.O.	at the by th tache	hys	9 □ Unknown 9 □ Unknown		
	ires tha signed b	by	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I. 236	e. Did tobacco use contribute to the cause of death?
ord	w requir been si should I	Completed			1 Yes 2 Probably 4 Unknown
3ec	has b	nple		248	a. Was an autopsy autopsy grindings available prior to completion of cause of
a				1	performed? death? Yes 2 No 1 ☐ Yes 2 ☐ No
=	sicial certi irecto	Be c	25. Was case referred to medical examiner? 1 Yes Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death (Check 3 □ DOA Other: 4 Vursing Home 5 Γ	
0	g Physer this eral di	7: To	27. Manner of Death 28a. Date of Injury 28b. Time of		☐ Residence 6 ☐ Other (Specify) scribe how injury occurred
<u>0</u>	ath. r: Aft	atio	Dending (Month, Day Year) Injury 2 ☐ Accident Investigation	Work? M 1 ☐ Yes 2 ☐ No	
Division or Vital Records,	r Attencer death	Certification:	3 ☐ Sulcide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Could not be determined 28e. Place of injury - At home, farm, stree building, etc. (Specify)		ation (Street and Number or Rural Route Number,
	ital or A				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier Check only (Check only one) Medical Examiner: On the basis of my knowledge, death of the basis of examination and/or invegand manner stated.	occurred at the time, date and place, and due stigation, in my opinion, death occurred at the	to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)
	To the within 2 To the complex	Med	one) and manner stated. 29b. Signature and title of certifler	29c. License number	29d. Date signed (Month, Day, Year)
	⊢≯Fŏ		1 Haroela	025112	04/10/2007
	λ		30. Name and address of person who completed cause of death (Item 23a) (Type. Pr	int) A A A A A A A A A A A A A A A A A A A	5 101 04 States 14:10
	4 /		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr Tahoora Kawaya 20) Crossro	ads Drive Suit	1117 Cultys Miles
	Sta		31. Date filed (Month, Day, Year)		
	Registr	ar	APR 1 1 2007		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 9, Day 2007 Physician 5:45 D M Carl Moore, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford Joppa 1002 Beall Dr. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 07/28/1932 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 74 1 X M 2 ☐ F Maryland 212-28-6707 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County a! Hygiene. other than "ratural" or items 23a or 28a-f show vent, the Medical Examiner must be notified at MD Harford Joppa 1 ☐ Yes 2 X No **Funeral Director** death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21085 1002 Beall Dr. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after oner of Health and Mental Hygiene. 1 XYes 2 No WWII If Yes, Give Year or Dates: Korea 1 Never Married 2X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Appliance Technician General Electric ith and Mental Hygie 27 Is marked other it r traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be Loretta Clemens LLewellyn Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 Is any injury or other trauonce. Lina F. Moore/Wife 1002 Beall Drive Joppa Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/13/07 Baltimore, MD Parkwood Cemetery 4 ☐ Donation 5 ☑ Other (Specify) Entomoment 21. Signature of Funeral Service Licensee Kimperly Davidson 22. Name and Address of Facility 5305 Harford Rd. Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** V Eller disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit Due to (or as a consequence of): Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for 5 Other (specify) ed by the a detached for 1 ☐ Yes 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autopsy 2 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one. To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manuar of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury Natural 5 Pending investigation 2 ☐ Accident 2 🗌 No 1 🗌 Yes 3□ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

State Registrar

(Check only one) 29b. Signature and title

		•	For State Registrar	State of Maryla	-	artment of H rtificate of I		Mental Hy	giene	007	11423	
			1. Decedent's Name (First, Middle, La	st)	·			2. Date of De Month		Vone	3. Time of Death	
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	xamin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Deat	h	4c. Cou	inty of Death		
			Joseph Richey Hos	pice		Baltimor						
Fur	neral		Social Security Number 6. S	ex 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Di Sept 2	th ay, Year)	9. Birth	place (State or Foreign ntry)	
Dire	ector		261-06-2763	2397 2017	70 Yrs.			Sept 2	3, 193	6 Urag	uay	
and and	_	1	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits	
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with	T De	0	130 Racetrack Rd.			20725			Uragua	У		
death	T I	Funeral	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.	Was Decedent of H	ispanic Origin? (S	pecify Yes or No	o- 14.	Race - Ameri		
after o	8		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No	i	If Yes, specify Cuba 1 XYes 2 No		to Hican, etc.)		Black, White,	etc.	
Source Survey	Exa	ρ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		LATES ZLINO	Specify: Ura	aguarian	. Spi	ecify: Whi	te	
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iaryland ZIZIS-UUSO 2 should be filed within 72 hours after death with the Maryland and Menial Myglene.	matic	၉	19a. Informant's Name/Relationship (Type Print)	19h Maili	ng Address (Street			per City or To	wn State Zi	n Code)	
Man d 2 st lth and			Robin Graham/POA/	• • • • • • • • • • • • • • • • • • • •		Duvall Ro					,	
Head	other		20a. Method of Disposition	20	b. Place of Dispo	osition (Name of	1	Date	20c. Locati	on - City or T	own, State	
TOT Pages ant of	yor		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		•	matory or other plac ie Cremato		11/07	Beltsv	ille,	MD	
DESILIMOTE, MARYIANG ZIZIS-UUSO permit. Pages 1 and 2 should be lifed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.	in in	1	21. Signature of Funeral Service Licer		-							
	and and a		Barale LH	of to Mo	01251 Be	verly L.	Heckrott	te, P.A.	Clark	ville,	784 MD 21029	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the d	eath. Do not en	ter the mode of dyin	ng, such as cardia	c or respiratory a	ırrest,		Approximate Interval Between	
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death cer	foru	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 F	etal death 3	Ectopic pregnancy Other (specify)	1		230.	Date of deliv Month	Day Year	
j å	peyo	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	51 364411 31							
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ords, F.O.	should be detached for use as							10	Yes 2□N	lo 3∏Pro	bably 4 Unknown	
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VITAL MEC vicion: The lav	page 2	E C							ormed?	prior to co death?	ompletion of cause of	
VITAI iicien: T	or, p	ပ	25. Was case referred to medical	*			26. Place of De	1 ☐ Yes ath /Check only	20 No	1 🗌 Yes	2 No	
ysick	director,	0 8	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 🗌 ER/Outpatie	nt 3 DOA Oth	05	dome 5 ☐ Res		Other (Speci	NH proice	
VISION OF VITA Attending Physicien: or death.	eral	ü	27. Manner of Death	28a. Date of Injury (Month, Day Yea.	28b. Time of	f 28c. Injur Wor		28d. Describe		curred	1100	
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Hospital or Attend 24 hours after death	ely fi	edical	(Check only Medical Example (Check only Medical Example)	ysician: To the best of my niner: On the basis of exam	knowledge, deat nination and/or in	h occurred at the tire to the tire tire to the tire tire to the tire tire to the tire tire to the tire tire to the tire tire to the tire tire to the tire tire to the tire tire to the tire tire to the tire tire to the tire tire to the tire tire to the tire tire to the tire tire to the tire tire to the tire tire to the tire tire to the tire tire to the tire tire tire to the tire tire to the tire tire to the tire tire to the tire tire tire to the tire tire tire tire to the tire tire tire tire tire tire tire tir	me, date and place pinion, death occ	e, and due to the urred at the time	cause(s) and , date and pla	d manner as : ice, and due t	stated. to the cause(s)	
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N W.	2 8		State of Certified			17:	1170		29d. Date signed (Month, Day, Year)			
1	2		180 NV	completed source of description	Itom (22a) (Time	Print	11/0		MAKI	11,20	/ /	
	9		30. Name and address of person who	completed cause of death	X38 /	VFILL	ICH R	allimo	re M	0 7.0	al.	
fac	Sta	te.	31. Date filed (Month, Day, Year)	Registrar's S	ignature	- UNIAM	01	WIII.				
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07-02631		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.									
Theodore Murra	State of Maryland / Department of Health and Mental Hygiene										
		1- For State Certificate	of Death		Re	g. No.	1 1142				
Physicia		Decedent's Name (First, Middle,Last)			2. Date of Death	า	3. Time of Death				
Medical Exami	ner	Theodore Mur 4a. Facility Name (if not institution, give street and number)	ray		April 6, 200	Day Year D7	1519 hrs				
				r Location of Death		4c. County of Deat	h				
		76 Pennsylvania Avenue Apartment 309	Westminst			Carroll					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	f Under 1 Ye Months Dar		8. Date of Birth	h(MM/DD/YYYY) 9. Bi Forei					
Director		219-60-8974 1×M 2 = 54	Yrs.	ys Hours Will.	Nov. C		ountry) MD				
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Baltimore, permit. Pages I an Department of He. Important: If ite	ı	21. Signature of Funeral Service Licensee	2 Name and Address	s of Facility		D WITTER TO	<u> </u>				
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/Medical Examiner	ı	Immediate Cause (Final disease a. Narcotic (heroin) into	xication				Death				
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e law	ם			· · · · · · · · · · · · · · · · · · ·	autops	ned? death?	completion of cause of				
tal Rection: The certificate ector, page		25. Was case referred to medical	26 Plac	e of Death (Check or	1 Yes 2	No 1 ✓ Yo	es 2 No				
Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be en rs after death. 31 Director: After this certificate has been signed by the attending physician led in by the funeral director, page 2 should be detached for use as the burial	Be	examiner? Hospital: 4 Jacobiant 2 FB/Output		Othor		Residence 6 🗸 Othe	r Scene				
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Sicolar Atte	<u>[</u>	28e Place of Injury At home farm s	14 hii			reet and Number or Ru	ral Route Number, City				
Divis: pital or At ours after d neral Direct filled in by	텕	Suicide Suicide Getermined (Specify) House			or Town Sta	_{lvania} Westm Lvania Ave, A	rinster MD				
Hospital Hospital 24 hours Funeral		29a. Certifier	courred at the time, d								
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of examination and/or invest									
To Kit	Me	and manner stated. 29b. Signature and title of certifier	29c. Licens	se number		29d. Date signed (Mo	nth, Day, Year)				
	}	Marine Mrs While	O.C.	M.E.		April 7, 2007					
VL NO	ŀ	30. Name and address of person who completed cause of death (Item 23a)	1								
Bills			Penn Street, E	Baltimore, MD 21	1201						
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1954								
Regist		APR 1 1 2007	2 1								

ORIGINAL

07-02591 Hattie I McChure

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Hattle L. McClure	E	- For State Registrar	tate of Maryla		ertificate d		d Menta	al Hygiene	Reg. N	2UU o.	/ 1142;
Physician Medical Examina		Decedent's Name (First, Middle Lee McClu						2. Date of I	Day	/ Year	3. Time of Death 0630 hrs
A Henry		4a. Facility Name (if not instituti		mber)	-	4b. City, Town, or	Location of	April 5,		4c. County of Dea	
<i>.</i>		424 West Mosher Str				Baltimore					
Funeral Director		5. Social Security Number 212-48-0113	6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under	24Hrs. 8. Date of 01/13	,	Fore	Birthplace (State or eign Country) MD
any		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Loca	ation					10d. Inside City Limits
and show nce.	5	MD				Ba	1timore	e			1 X Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tien 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	10e. Street and Number 424 Mosher Stree	et	•		10f. Zip Code	1217		10g. C	itizen of What Co USA	ountry?
death with	runeral		12, Was Dece Armed Fo 1 Yes	rces? 2 X No		as Decedent of His Yes, specify Cuban			No-	White, etc.	erican Indian, Black,
urs after tural",	⋧┝	3 Widowed 4 Di 15. Decedent's Education (Spe	vorced If Yes, Give Year or Dates: ecify only highest grad		16a. Decede	Yes 2X No		nd of work done	16b	Specify Can Kind of Busines	American s/Industry
6 172 hou an "nau	Completed	Elementary/Secondary (0-12)			during i	most of working life.	DO NOT us	se retired)			
21215-0036 Muld be filed within 7 Mental Hygiene marked other than cevent, the Medica	E -	12 17. Father's Name (First, Middle	a Last)			unknown	18 Mother's	Name (First, Midd	le Maide	unknown	
215. 215. be filed atal Hy ked of	Bec	John M					0.171011101	Hattie			
D 21 should in Meil is mair	۲	19a. Informant's Name/Relation				ng Address (Street					
and 2 s ealth a tem 27		Danetta Gabriel / 20a. Method of Disposition	Daughter	200		Williston Spition (Name of cen		Apt. 2; E	altin	ore, MD	21229 or Town, State
Baltimore, MD permit Pages and 2 sho Department of Health and Important: If item 21s injury or other traumati	- 1	1 X Burial 2 Cremation			crematory or c	other place) **Cemetery	C	04/12/2007		Baltimore	, Maryland
altir rmit. P spartme uportai		4 Donation 5 Other S 21. Signature of Funeral Service				Name and Address	of Facility	Wylie Fu	neral	Home, P.	Α.
	-	23a. Part I. Enter the disease, o	r complications that ca	sused the dea	th. Do not enter	538 North G	ilmor S	Street; Bal	timor	e. Marvla	
Physician Medical Examiner	ł	failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	e on each line.	clcerotic	cardiov	ascular dis					Between Onset and Death
		Sequentially list conditions,	b								
		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a	consequence	of):						
60, ate be execute hysician and te burial - transit		events resulting in death) Last	Due to (or as a	consequence	of):			·			
60, ate be exc hysician e burial -	edici	XUNPENDED	AMENDED PI	I,27, p	erME, g86	7, 5/10/07 ⁻	IT		- 12	20 d Data of delic	
cords, P.O. Box 68760, law requires that the death certificate be execute has been signed by the attending physician and 2.2 should be detached for use as the burial - trans	cian	IF FEMALE: (3b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 ✔ Ur	4 Pregn	irth ant at time of	2 F	etal death 3 [Ectopic p	pregnancy		23d. Date of delive Month	Day Year
D. B. It the de ached f		Part II. Other significant cond	9 Olikilo		t resulting in the	underlying cause g	iven in Part	1. 23e. D	d tobacc	co use contribute	to the cause of death?
ires tha	o D	Liver cirrho	sis					1	Yes 2	No 3 P	robably 4 🗸 Unknown
ords w requ	Completed								as an utopsy erformed	prior to	autopsy findings available o completion of cause of
Rec The la icate h	<u>ا</u>							1 🗸 Y	s 2		
ital sician: s certif	å	25. Was case referred to medic examiner?	Ulannital: eres	npatient 2	ER/Outpatie	prosety .		Nursing Home 5	Resi	dence 6 🗸 Ott	ner: Scene
of V ng Phys of Phys offer thi neral d	<u></u>	1 Yes 2 No 27. Manner of Death	28a. Date (Month,		28b. Time of	L	y at Work?			njury occurred	
sion ttendii death. rtor: A y the fu	atio		nding estigation				es 2 1				
Division of Vital Records, P.O. Is or Attending Physician: The law requires that t is after death. "al Director: After this certificate has been signed by leed in by the funeral director, page 2 should be detacted in the control of the control o	Certification:	det	uld not be ermined (Specify)	e of Injury - At	home, farm, str	eet, factory, office b	uilding, etc.		n (Stree n, State)		Rural Route Number, City
in the bar of the bar	Medical Ce	29a. Certifier 1 Certifying I	Physician: To the bes	of examination	edge, death occ and/or investig	urred at the time, da	ite and plac	e, and due to the ourred at the time, o	ause(s)	and manner as si place, and due to	tated the cause(s)
To with	Me.	29b Signature and title of certif	and manner si	tated.		29c. License	e number		29	d. Date signed (f	Month, Day, Year)
		labul	(or A	e.		0.0.1	М.Е.		A	oril 5, 2007	
		 Name and address of person Zabiullah Ali, M.D. 	n who completed caus Assistant Medic			nn Street Balti	imore. M	D 21201			
Sta	te	31. Date filed (Month, Day, Year			ature	_					
Registr	ar	APR 1 1	2007	love s	U. ASSO						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend#5, perFH, C867, 5/8/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** 9:27 P. M MARGARET ELIZABETH 2007 MEHRING April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Union Memorial Hospital N/ABaltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🖸 F Yrs. 22-3328 93 26, Nov. 1913 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 TNo Director Maryland Baltimore **Baltimore** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21210 6007 Hunt Ridge Road U.S.A. Funeral Apt. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. hours after 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: <u>م</u> 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical 12 years <u>Medical Secretary</u> permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, if ulth and Mental Hvr. 7 is mark 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Henry Mehring Daisy Estelle Thompson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6007 Hunt Ridge Road Apt. 3321 Baltimore, Maryland ce of Disposition (Name of Date 20c. Location - City or Town, State Mary Louise Mehring (niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1

Burial 2 □ Cremation 3 □ Removal from State Baltimore Cemetery 4 Donation 5 Dother (Specify) 4-7-07 Baltimore, Maryland Mitchell-Wiedefeld Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6500 York Road Baltimore, Maryland errais Approximate Interval Between Poset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final la com wws Physician disease or condition resulting in death) /Medical (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-transi and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2□No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No 1 ☐ Yes 1 Inpatient 2 XER/Outpatient 3 ☐ DOA 28a. Date of Injury 28h. Time of 27. Manner of Death 28d. Describe how injury occurred

P.O. Box 68760 Division or Vital Records, Hospital or Attending Physician:

Certification: after death filled in by

1 Natural 5 ☐ Pending investigation 2 Accident 3 ☐ Suicide

29a. Certifier

6 ☐ Could not be determined 4 ☐ Homicide

(Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and title of certifier 29b. Signatuje

29c. License number

TOWSKI M WZVL

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. HARWI, m 6701 Ni Charles

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 1 1 2007



DHMH 17 Rev 1/2001

To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 11:20 PM Rudolph Mills 2007 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 X M 2 □ F 87 198-01-9847 February 23,1920 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 X No Catonsville Maryland Baltimore **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 912 S. Rolling Rd. 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: WW T Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Be Completed by 3 X Widowed 4 ☐ Divorced white WW II 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) analyst/supervisor Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked of Miliewski Sophie Pautuk 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Allison Benhoff/daughter 14224 Sawmill Ct. Phoenix, MD 21131 of Health a 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Important: If any Injun Green Mount CrematoryApr. 7,2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
Religione. MD 21212 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Ant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner ans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Examiner physician and the burial-transit Due to (or as a consequence of): Completed by Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Por in the past 12 months? Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 1 □ Yes 2 □ No. 9 Unknown 9 Unknown signed by d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 2 No 1 TYes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 funeral c 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔁 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

death certificate be executed P.O. Box 68760 Division or Vital Records, within 24 hours after death

To the Funeral Director:
completely filled in by the ö To the Hospital

Pages 1 and 2 should be

State Registrar

DHMH 17 Rev 1/2001

APR 11

1

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

6701 N. Charles Bmc 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c, License number

25205

29d. Date signed (Month, Day, Year)

pril 6, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Helen Williams Ohrenschall 1:39 p^M April 6,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital Baltimore n/a If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Vrs 217-22-4874 81 3.1925 Director Oct. Maryland Usual Residence of Decedent should be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at ∏Yes 2∏No Director Maryland n/a Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 830 W. 40th Street 21211 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② (No If Yes, Give Year or Dates; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XXNo Specify White Specify Be Completed by 3€Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carroll Edgar Williams Malvina Anderson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun John Ohrenschall (Son) 3014 St. Paul Street Baltimore, Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 💢 remation 3 ☐ Removal from State Green Mount Crematory 4/10/07 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. of Funeral Service Licens 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or compli-shock, or heart failure. List only on s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Arteriosclerotic Cardiovascular Disease **Physician** Years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform 1 Yes 2 rmea? 2**√**□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred injury 5 Pending investigation 1 Natural 1 Yes 2 No or Attend after death. Director: 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State Registrar

DHMH 17 Rev 1/2001

APR 1 1 2007

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D 13657

April 9,2007

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND TIEM#27 DerPHYS G866, 4719 07, ws

State of Maryland / Department of Health and Mental Hygiene OF AMEND TIEM#18, Usa DerTMF 1, G866, 4720 07, ws Certificate of Death 2 Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Harold Gordon Porter /Medical County of Death 4b. City, Town, or Location of Death Facility Neme, (If not institution, give street end number) Examiner If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number n yrs. lest birthdey) 8. Date of Birth (Month, Day, **Funeral** Days 1 X M 2 ☐ F Yrs 03/23/1924 Pennsylvania 83 Director 202-07-6489 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Locetion Pages 1 end 2 should be filed within 72 hours aftar death with the Marylen ment of Health end Mantal Hygiana.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f ahow ury or other traumatic event, the Medical Examine, must be inotified at 1 ☐ Yes 2 No MD Funeral Director Baltimore Baltimore 10g. Citizen of What Country? 10e Street end Number 10f. Zip Code U.S.A. 9416 Dawn Drive 21236 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Dates: ₩₩ Т1 Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ♥ No Specify. Specify à 3 ☐ Widowed 4 ☐ Divorced WW II White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 12 Self-Employed HVAC Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Eleanor Elinor Ruth Detweiler Harold Ward Porter 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ruth J. Porter (wife) 9416 Dawn Drive - Baltimore, Maryland 21236 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Depertment of Important: If Its any Injury or o 1 N Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Michael Luth.Ch.Cem. 04/11/07 Baltimore, Maryland 22. Name and Address of Fecility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licenses 11750 Belair Road - Kingsville, Maryland 21087 tha 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence ol): Physician/Medical Examiner or Attending Physician: The law requires that the daath certificate ba axecuted use as the bunal-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Unknown 1 ☐ Yes 2 ☐ No 3 Probably Š þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medicai Certification: To 1 Yes 2 VNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ours after death. ate of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of De eth 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Plece ol Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 4 ☐ Homicide within 24 hours a

To the Funeral C

completaly filled To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 01418 of death (Item 23a) (Type, Print) 31. Date filed (Mg 32. Registrar's Signature State Registrar

	For		Department of Health and		and alternation	Reproduced to
1-	For State Registrar		Certificate of Death	Reg. No.		
1. [Decedent's Name (First, Middle, Last) AROLY N	2 - 2 -	Υ,	2. Date of Death Month Day	ear	3. Tir

Physician /Medical Examiner

	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea	ath	4c. Count	y of Death		
♣.			HAVEN NUI	2sing Ho	ME	3939	enhus	+ Ave	Ba	Stronge Cat	V	
Ar ·	Funeral		5. Social Security Number 6. Se	7	rs. last birthday, Yrs.	Months Days	If Under 24 Hi Hours Mir	8. Date of Bi (Month, D		Birthplace (State or Foreit Country)	gı	
	Director		216-32-7999 Usual Residence of Decedent	JM 2LXF 70	TIS.			02 1	4 37	MD	_	
P.C.	ow m		10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limit	ts	
Man	Many	ţ	MD Balti	more	Randa	llstown				Yes 2□N	10	
ŧ.	r 28e	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?	_	
3	23a o		10701 Chapelda	le Road		2.	1133		U.	S.A.		
0	E LIE	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Specify Yes or N	o- 14. Rac	ce - American Indian, ck, White, etc.	_	
5-0036	al', or it	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 27 No If Yes, Give Year or Dates:		1 ☐ Yes X☐ No	Specify:	110 / 1104/1, 010.7	Specil			
Maryland 21215-0036	The many and the many and the many and the many and the many and other than "natural", or items 23a or 28s-1 show event, the Madical Exercitive mast be notified at	Completed	15. Decedent's Edi (Specify only highest grad		(Give	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		orking		usiness/Industry More City	_	
ביים	than	dmc	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+) 5yrs+						l System		
ט פ	Hygi other	Be C	17. Father's Name (First, Middle, Last)	0,10			18. Mother's Na	ame (First, Middle			_	
ylan			Frederick Woods				Caroly	n Jack	son			
מיק ק	and N and N and In		19a. Informant's Name/Relationship (T	ype, Print)	19b. Maili	ng Address (Street	and Number or F	Rural Route Numb	er, City or Town	, State, Zip Code) 21133	_ >	
Σ , ε	t Health and Mer them 27 is marks other treumatic		Rodney Perry-So	n	1070	l Chape	ldale F	Road, R	andall	stown, Md ¹³³)	
Baltimore,	i of He if Item or oth	13	20a. Method of Disposition	20b	. Place of Dispe	osition (Name of matory or other place	(e)	Date	20c. Location	- City or Town, State		
Ĕ	i i i i		4 Donation 5 Other (Specify,	IOITIOVAL ITOTIC STATE			1	1/16/07	Owing	s Mills, Md		
30 11	Departr Departr Imports eny inju		21. Signature/of Funeral Service/Dicens	99		2. Name and Address arch F/I						
п з	KOE 5 a		Jun 13.	Kek	4	300 Waba	ash Ave	, Balt	imore,	Md 21215		
			23a. P rt1. Enter the disease, or comp six ck, or he in failure. List only o							Approximate Interval Between		
	hysician		Immediate Cause (Final disease or condition resulting in death)	. Severe	adu	anced	den	nenti	a	Onset and Death		
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		Li di	Sequentially list conditions,	b. ————————————————————————————————————	equence of):						_	
/ bet	unsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		- 1							
5U ,	sicien and burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a cons	equence of):						-	
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DOX	lendin r use	an/h	230. Was decedent program	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy				te of delivery		
. 8	by the at	Physician/Medical	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant at time of 9☐ Unknown		Other (specify)			Mo	onth Day Year		
7. la D. ef	7 7 0	Phy	Part II. Other significant conditions co	ntributing to don't but not s	aculting in the w	a dach ian an an an	an in Oard I	22° Did		tribute to the cause of death?	-	
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VITAL MECOFGS,	has pe 2	Completed by		sorder				24a. Was	an 24b. psy prmed?	Were autopsy findings availab prior to completion of cause of death?	ite f	
.				strokes				1 ☐ Yes	2 No	1 Yes 2 No		
VIII	is certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	fospital: 1 Inpatient 2	□ FD/0	Othe		ath Check only				
o ş	er this	\vdash	27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time o	IL 3L DOA	4 Dawursing	Home 5 Resi	dence 6 Oth		_	
	death. tor: After the funer	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		<br Yes 2 □ No					
DIVISION For Attending	er de recto by th	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str	eet, factory, office		28f. Location (City or To	Street and Numb	per or Rural Route Number,	-	
2 <u>\$</u>	ret Di	Cer										
HOSD GSD	124 hours after death. • Funerel Director: After this certification in by the funeral director.	edical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	n occurred at the tim vestigation, in my op	e, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) and madate and place,	anner as stated. and due to the cause(s)		
Toth	within 2.	Me	29b. Signature and title of certifier	A. O.	,	29c. License	number		29d. Date signe	d (Month, Day, Year)		
			My	/all		D18	327		April	9th 2007		
	2		30. Name and address of person who co	impleted cause of death (It	em 23a) (Type.	Print)					Wasse	

DHMH 17 Rev 1/2001

State Registrar MOGES GE 31. Date filed (Month, Day, Year)

Gebrenariam: 4660 Wilkens Are H203 Bello 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Barbara Peake 11:55 p^M April 8, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Quail Run Assisted Living Parkville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year)

Months Days Hours Min. (Month, Day, Year)

June 23, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 134-09-3088 Director 87 1919 New York Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Deperment of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or itema 23a or 28s-f ehov any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9902 Walther Avenue 21234 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White þ Specify: Specify 3 →Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Housewife Her own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Eastwood Susan Farrer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Warren Peake, Jr. 6310 Chster Park Drive Chincoteague, VA 20a. Method of Disposition
1 월 Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 4/11/07 Parkville, MD 22. Name and Address of Facility
Miller-Dippel Funeral Home, Inc.
6415 Belair Road Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death a CORONARY ARTERY DISEASE Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner VEIN THROM BOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine XPERTENSION or Attending Physician: The law requires that the death certificate be executed ending physicien and use as the burial-transit Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Medical Certification; 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a
To the Funerei I
completely filled Fo the Hospital 1 Dertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) OVIANU K TULKE Name and address of person who completed cause of death (Item 23a) (Type, Print) Place Dundalk 4D 21222 JULIG 2 Ma 32 pegistrar's Signature 31. Date filed (Month, Day State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per fb 8866 4-11-07 yt State of Maryland? Department of Health and Mental Hygiene.

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 08:45 M 04 05 Robinson Ruth /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 1 □ F Director 212-16-3887 88 06 19 MD Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10d. Inside City Limits 10b. County or 28a-f show Examiner must be notifled at 1 X Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 3 21212 U.S.A. 4532 St. Georges Ave Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Snecify Black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City 12th grade Teacher 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Norman Fleming Milton Walker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georges George Ave, Baltimore, Md 21212 Lawrence Robinson-Husband 4532 St. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 4/12/07 Owings Mills, Md 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License March F/H West 4300 Wabash Ave, Baltimore, Md h 21215 23a. Part1. Inter the disease, or complicated that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): Box 68760. physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? certificate To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Tother (Specify) 1 ☐ Yes 2 ☐ No P 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural Injury 5 Pending investigation 1 □ Yes 2 □ No 2 Accident To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cortifier un 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Registrar

Year



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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 6 per fh 9866 4-23-07 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** O DY 11 5'.24 A M Kedmon 200 IMMID 10 /Medical Facility Name (If not institution, give street and number) 4b. City , Town, or Location of Death County of Death Examiner Baltimore Washington Medical Center Anne Arund Gley Burne 8. Date of Birth (Month, Day, Jan • 7, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days ^{Year)} 1948 Maryland Hours 59 214-50-6961 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County la or 28a-f sh 1 □Yes 2 No Director Marvland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21060 1314 Tarrant Rd. United States is marked other than "natural", or items 23a aumatic event, the Medical Examiner must be Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 ☐ Yes 2 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☒ No Specify. <u>م</u> Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Steward Redmon Bessie Amelia Feaster 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1314 Tarrant Rd., Glen Burnie, Maryland 21060 Paula J. Redmon / Wife April 14, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State Important: If It any injury or o once. Glen Haven Mem. Park 2007 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) I Eur rai Serv 21. Signatu Kirkrey-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 5) 23a. Part1. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nse and D Immediate Cause (Final **Physician** 21218 disease or condition resulting in death) /Medical to (or all a consequence of): Examiner Vertropenia Sequentially list conditions, if any, leading to infine riate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed Larcinoma and Due to (or as a consequence of): burial-t P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) ed by the a 1 □ Yes 2 □ No. 9 ☐ Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 Syndroma 1 Pres 2 No 3 Probably 4 Unknown vena CAVA Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed! Yes 2 No certificate 1☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA r this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of Injury (Month, Day 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Year) To the Hospital or Attending 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) D0022463 MY n who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Dr. Glan Burnis, MD 2106/ STUDIT Jacobs

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 11

2007

32. gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Marie Anna Scheffel April 8 /Medical 2007 7:35 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Heartlands Assisted Living Ellicott City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** Days 220-24-9674 Director 15, 1915 Illinois Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anones. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Director Baltimore 1 ☐ Yes 2 X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 613 Coleraine Road 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2**K**) No ive 21215-0036 1 ☐ Yes 2 No þ Specify White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rudolf Malinofski Annie Crofoot 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernon L. Scheffel Husband 613 Coleraine Road; Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State 4/13/2007 Baltimore, Maryland Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature Funeral Service Lice vice 1630 Edmondson Avenue; Catonsville, Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 7m5 /Medical Due to for as a consequence of): Examiner the selesti Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month signed by the at d be detached for 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed ves 2 No has 1□ Yes 2∏ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Varsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director. 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainler as stated.

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(Month. Dav. Year) State Registrar APR 1

29b. Signature and title of certific

1 2007 32. Registrar's Signature

on to Cotronly m

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend #26 per FH C866 Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year FAY AILEEN SASS 8:55 AM March 28, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 93 Kingbrook Road Linthicum Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 M 2 KF Yrs 219-12-3408 84 Jan 26, 1923 Maryland Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Yes 2 No Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 93 Kingbrook Road 21090 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify 3 XWidowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Self-employed Beauty Salon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George T. Chaney Myrtle Wellham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Dempsey (Granddaughter) 104 South Longcross Rd., Linthicum, Md. 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Pk 3/30/2007 Glen Burnie, Maryland 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
237 E. Patapsco Ave., Balto., Md. 21225-1856 21. Signature of Fundal Service Licensee Kevin E Ecker 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death O THRIVE disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, 1 2 y, 1 2 d. g to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Directo (or as a consequence of resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 21 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check on one 1 ☐ Yes 2 Hospital: Other: 1 Inpatient 2 ER/Outpatient 3□ DOA 5 sidence 6 Other (Specify) Home 28c. Injury at Work?

Examiner physician and is the burial-transit \mathcal{H} $\mathcal{A}\mathcal{E}$ Division of Vital Records, P.O. Box 68760, 99 as igned by the attending be detached for use as signed by To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Physician

/Medical

Examiner

Directo

by Funeral

Completed

Be

Funeral

Director

27 is marked other then "neturel", or Items 23e or 28a-f show treumatic event, the Madical Exemples must be notified at

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ent: If item 27 is marked other then "neturel", or Ite

permit. Pages 1 Department of H Importent: If ite eny injury or ot once.

Priysician

/Medical

with the Maryland

death

Examine Physician/Medical à Completed Be Certification:

27. Manner of Death 2 Accident 3 🔲 Suicide 4 Homicide

29a. Certifier

31. Date filed (Mor

28a. Date of Injury (Month, Day Year) investigation

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

D 2 9303

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Pritfying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

5 Pending

ternande3

6 Could not be determined

516 N Rolling Rd ste 32. Registrar's Signature

State Registrar

D

DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Irene V. Sullivan 7:00 P M April 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1917 Glendora Drive District Heights Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 578 34 7547 Director 85 Aug 26, 1921 Pennsylvania Usual Residence of Decedent should be filed within 72 hours after death with the Maryland r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2□No Director Maryland Prince George District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Exaπiner must be 1917 Glendora Drive 20747 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ Yo If Yes, Give ★ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by ¥√√Widowed 4 □ Divorced of Health and Mental Hygiene.
Item 27 is marked other than "natul other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Psychiatric Hospital Psychiatric Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna (UNKNOWN) Joseph Spigut ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any injury or other traun once. Anna Sullivan Warren (Daughter) 1917 Glendora Drive, District Heights, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) April 25, 2007 20a. Method of Disposition 1 Deurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Arlington, Virginia 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d noral Service Alexandria Ferry Road, Clinton, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** disease or condition resulting in death) Severe Cardiomyopathy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🌠 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗍 Yes 2√No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performe 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 TResidence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo 2 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation 1X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier D41978 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 4000 Mitchellville Road, #312, Bowie, MD 20716 Nader Tavakoli 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

APR 1 1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SPILIOPOU LOS 0945M APRIL aust /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northwest HUSPITAL Kandallstown Baltimore County. 5. Social Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. Director 71 JAN 26, 1936 GREECE Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 □ No _XX Director NY QUEENS BAYSIDE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 15-25 BELL BLVD. Funeral 11360 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No WHITE Specify <u>^</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 WAITER RESTUARANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ ANASTASIOS SPILIOPOULOS EVDOKIA ECONOMOU 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGIA ADAMAKOS 15-25 BELL BLVD. BAYSIDE, NY 11360 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ₩Burial 2 ☐ Cremation 3 ₩Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NASSAU KNOLLS 4.13.07 PORT WASHINGTON, NY 21. Signature of Funeral Service Lice's 22 Name and Address of Facility
FINK FUNERAL HOME, P.A. t/a MARYLAND MORTUARY SUPPORT K. GREGORY ATNK M01148 426 CRAIN HWY S GLEN BURNIE, MD 21061 23a. Part . Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in 4 ath) Physician aftherosclerute Covonary Vessel /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): -burial-Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy performed? Yes 2 No page ; certificate 1☐ Yes or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 □ DOA 1 Inpatient Medical Certification: To 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death. neral Director: A' filled in by the fu 1 Tyes 2 Accident 2 □ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1. **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D0057634 APRIL 2007

Registrar

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COURT

OLD

31. Date filed (Month, Day, Year)

ORIGINAL

Randallstown, Maryland

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 04 04 2007 /Medical Rochelle Renee' Swann 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6 Raylon Ct. Apt. D Nottingham Baltimore If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Min. Hours 1 M 2 M Director 48 220-72-7988 12/29/1958 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County show other traumatic event, the Medical Examiner must be notified at Director MD Baltimore 23a or 28a-f Nottingham 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6 Raylon Ct. Apt. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within inent of Health and Mental Hygiene. Int: If Item 27 Is marked other than " Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Leroy Townes, Sr. Barbara Ann Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 Is any Injury or other trau Barbara Townes/Mother 8123 Church Lane Windsor Mill, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State Apr 10 4 Donation 5 ☐ Other (Specify) 2007 Baltimore, Maryland King Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 23a. Part1. Error the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8717 Green Pastures Drive Baltimore 0 Immediate Cause (Final **Physician** disease or condition resulting in death)

/Medical Examiner

the

The law requires that the death certificate be executed

Box 68760.

P.O.

Division or Vital Records,

or Attending Physician:

after death.

within 24 hours a To the Funeral I Hospital

l in by

Examiner

Physician/Medical

<u>Ş</u>

Completed

Be

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Certification:

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a	Due to (or as a consequence of):
b	Due to (or as a consequence of):
c	Severe marbid obesity Due to (or as a consequence of):
d	but to (or as a consequence of).

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death

4☐Pregnant at time of death 9□Unknown

3 □ Ectopic pregnancy 5 ☐ Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an

1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

3. Time of Death

Birthplace (State or Foreign Country)

Black

Maryland 21286 Approximate Interval Between Onset and Death

3 years

Year

10d. Inside City Limits

1 ☐ Yes 2 No

9:14 PM

Year

performed 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ ★ 6

25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 Natural 5 ☐ Pending investigation 2 Accident

1 ☐ Yes 2 No

3 ☐ Suicide

29a. Certifier

4 Homicide

6 Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Time of Injury Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Pype, Print) Dowlin Meguita 9101 Franklin

State Registrar

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend #10a, perFh, 6866, 4/11/07 TT Cartificate of Barrier Amend #10a, perFh, 6866, 4/11 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1:45 AM Saunders 04.06.2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimere OUSUN If Under 24 Hrs. Manor Care Phuxton If Under 1 Year 8. Date of Birth (Month, Day, 02.05 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 □ M 2 X F 219.22 6194 Usual Residence of Decedent Yrs. 80 Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Maryland. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No **Funeral Director** GTM. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2326 Midgemont 19 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Assistant 0915 dmin. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٥ Jathan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ft. Washington MD 20744 ate 20c. Location - City or Town, State lecraine Daurders 125 Lanham Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 □ Other (Specify) Hill Constey CU-12-07 Glenn Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaucha C. Cireera purarai zerus Vaushin C. Stress. 8728 Liberty Not Manula 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 728 Liberty Ind Mandallstan 21132 Approximate Interval Between Onset and Death Immediate Cause (Final Syndrome Physician PSIS disease or condition resulting in death) De days /Medical Due to (or as a consequence of): Examiner inonths Angre Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner VASCULIN disease be executed burial-tra Due to (or as a consequence of) cate has been signed by the attending physician page 2 should be detached for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy perform 2 No 1∐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) · mo m Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto. Md 6BMC 6701 31. Date filed (Month, Day Year) 32. Registrar's Signature State Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Carolyn Snead 04 80 2007 10:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Overlea Health and Rehabilitation Center Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6, Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 😿 F 217-16-1437 MD Director 80 11/12/1926 Usual Residence of Decedent death with the Maryland 10a. State 10d. Inside City Limits 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f show Exaπiner must be notified at MD 1 X Yes 2 □ No Director Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6116 Belair Road 21206 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene.

is marked other than "natural", or itel 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: African American Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be unk မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum orice. Ms. Lucas / Guardian 10 N. Calvert Street; Baltimore, Maryland 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Mount Zion Cemetery 04/11/2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 21217 638 North Gilmor Street; Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DAY Physician CENCIANUVASIUCAN /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, live to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner e attending physician and d for use as the bunal-transit that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) □Yes 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 2 1No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☐ 1\(\text{1}\) 2 ER/Outpatient 3 DOA ျှ 27. Mann - eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 24 hours after death, Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation neral Director: / filled in by the fi 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 - certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 74 7965 mn n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per doc 2866 4-11-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Staewen Christina L. March 31 2007 8:35 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster
If Under 24 Hrs. Dove Hospice House Carroll If Under 1 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 💢 F 216-52-6739 77 Director March 11, 1930 Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 X No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or 5 Examiner must be r U.S.A. Funeral 300 Sunflower Drive 21014 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th. Grade Cook/Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Christian A. Pages 1 and 2 should ဥ Staewen В. Mary Knapp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a : If item 27 is William Staewen/Brother 30611 Cedar Neck Rd. Unit #2203 Ocean View DE 19970 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ■Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 Other (Specify) Parkwood Cemetery 04/05/2007 Baltimore 21. Sign, are of Funera Service Licensee 22. Name and Address of Facility Miller-Dippel Fu 6415 Belair Road Funeral Home, oad Baltimore 1 21206 23a. Part1. Enter the disease of complications that shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 4□Pregnant at time of death 1 ☐ Yes 2 ☐ No ed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 8 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signat and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prive Owings mills MD 21117 23 Crossropd wruter 32. trar's Signature State 2007 Registrar

		,	1 - For State Registrar	State of	Marylaı	nd / Depa <i>Cei</i>	artmen rtificat			and M	lental F		ene	07	11442
			1. Decedent's Name (First, Middle, La	st)							2. Date of	Death	Davi	Vi	3. Time of Death
	Physici /Medi		Lillian Tuerke								Apri]	7,	Day 2007	Yeer	5:35 A ^M
	Examir		4a. Facility Name (If not institution, given	e street and num	ber)		4b. City,	Town, or	Location of	of Death			4c. Count	y of Death	
			Genesis Catonsv	ille Com	mons		Ca	tons	sville	9			Balt	imore	
	Funeral		Social Security Number 6. 5		. Age (In yrs	. last birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of (Month,	Birth	'earl	9. Birth	place (State or Foreign
	Director		217-09-2900	I ☐ M 2🖾 F	91	Yrs.	Months	Days	nouis	IVIII I.	Oct	3,1	915	Mary	land
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	ges 1 end 2 should be filed within 72 hours after deeth with the Maryland it of Heelih and Mental Hygiene. If item 27 is marked other then "naturel", or iteme 23a or 28a-f ehow or other traumatic event, the Medical Examinar must be notified at	Funeral Director	10e. Street and Number 25 Glenwood Aven	ue			10f. Zip	Code	21228	3		100	j. Citizen of USA		ntry?
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a	and and is mu		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	/ Route Nu	mber, C	City or Town	, State, Zip	Code)
Σ	end a		Ronald E. Tuerke	Son		25 G	1enwo	od A	venue	e; Ca	tons	i 11	e, MD	2122	.8
Baltimore,	of He		20a. Method of Disposition	70		Place of Dispo	sition (Nan	ne of ther plac	e)	C	ate	20	c. Location	- City or To	own, State
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DHMH 17 Rev 1/2001

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	/Medic Examin		4a. Facility Name (If not institution, given Future Care Nur			4b. City, To	wn, or Location on the control of th			4c. County		eorge's
	Funeral Director		442 14 8458	6ex 7. Ag XXM 2□F 84	e (In yrs. last birthda Yrs.	y) If Under 1 Months D	Year If Under Days Hours	Min. 8. Date Min. May	of Birth oth, Day, You IZ,	1922	9. Birthp Cour Henr	place (State or Foreign ntry) ietta, OK
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland St. Mar	y <i>s</i>	10c. City, Town or	Location	int				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	vith the	Funeral Director	10e. Street and Number	D 1 D	0 D 05	10f. Zip Co				. Citizen of V		
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9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ampi rightry or other traumatic evant, the Medical Examinat rights an once.	by	1 ☐ Never Married 2 ☐ Married 3√√Widowed 4 ☐ Divorced	Amed Forces? 1 Tyes 2 If Yes, Give Year or Dates:	No WWII	If Yes, specify		gin? (Specify Yes n, Puerto Rican, e	tc.)	Blac	k, White, Whit	etc.
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8760,	cate be executed bhysician and the burial-transit		resulting in death) Last	Due to (or as	a consequence of):							
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DIVIS	To the Hospital or Attending Physician: state as after death as a few death To the Funaral Director; After this certifica completely filled in by the funeral director;	Certification;	3 Suicide 6 Could not b 4 Homicide determined		ury - At home, farm, s c. (Specify)	treet, factory, of	fice		tion (Stree or Town, S		or Rura	l Route Number,
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	To t To tl	M	29b. Signature and title of certifier	M			cense number 51520			Date signed		
	1541		30. Name and address of person who	-							_	0032
	Sta	te.	Bahram Pishda 31. Date filed (Month, Day, Year)		1328 Sou ar's Signature	thern	Ave S.	E. Suit	310,	Wash	ning	ton DC
DHN	Registra AH 17 Rev 1/20	ar	APR 1 1 20		. J. A	assil .						
					ORIGIN	AL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 405PM 07 2007 /Medical (If not institution, give street and number, 4b. City, Town, or Location of Death c. County of Death **Examiner** 7. Age (In yrs. last birthday) If Under 24 Hi 6. Sex 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Min. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 No by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tealth - Urs 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname Be 2 19a. Informant's Name/Relationship (Type. Print). 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KO Baltimore, MD 21207 oris + He Durchter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State rematory 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 10 201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ite morrhage erebral /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Tohknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 DOther (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 DHatural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April, 7,2007 Cars in 00061199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 209, Touson MD 21204 5

Registrar

State

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2007 **Physician** Walter Eugene Windsor 8:00 PM April 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton 8. Date of Birth (Month, Day, Year) Feb 18, 1928 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days 1∏ M 2∏ F Hours Maryland **Director** 79 577 32 5093 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes XX No Maryland Prince George's Clinton Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9506 Gwynndale Drive United States 20735 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No if Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 Xlo Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Painter Self Employed 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edna Applen Edmund Windsor ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annamay Windsor (Wife) 9506 Gwynndale Drive, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory April 9, 2007 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD MO0251 21a.1 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician WESK disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but no<u>t resulting in the underlying cause given in Part i.</u> 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 250 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a Was an 1□ Yes ZZNo Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: Apatient 1 Tyes 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) To the Funeral Director: After this completely filled in by the funeral of 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of

31. Date filed (Month, Day,

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Month Vathanie 7:05 PM Apri 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Medical timore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Days 214-62-1832 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No ESSO Director ma. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 Marice Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White_etc 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 9 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) onstruction 12-th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mallace N Denjamin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ESSex 2 marice d. andra Wallace 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cemelen 4 □ Donation 9 □ Other (Specify) Kest 1401 Byer 21. Signature of Juneral Service Ligensee 22. Name and Address of Facility Baeto, md. 21220 P. march Funeral Home 23a. Part. Eppe the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or rear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cause (Final disease or condition resulting in death) Se Physician Sepsis

Due to (or as a consequence of): /Medical Congestive Heart Failure Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 文 Ûnknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 1 ☐ Yes certificate 2□ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

3 State

Registrar

e

31. Date filed (Month

Year) 2007

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Carre

07-02616 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Rodney Lee Watson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3 Time of Death Month Day April 5, 2007 **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 2027 hrs 4b. City, Town, or Location of Death 4c. County of Death 4120 Fallstaff Road Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In yrs. last birthday) Director Months Days Hours Min Country) M 1 X M 2 F Usual Residence of Decedent 10a. State Inv 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Yes 2 No notified at once death with the Maryland timore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country ā or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black med Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married Yes hours after If Yes, Give Year 3 Widowed 4 Divorced Yes 2 No specify: "natural", ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hou
Department of Health and Mental Hygiene.
Important: If ifen 27 is marked other than "nati
injury or other tranmatic event, the Medical Exa during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ASSISTENT 18.Mother's Name (First, Middle, Maiden Surrame) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, Date 120c Location Cityon Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State crematory or other place) 22. Name and Address of Facility Waughn C. Greene Fun Service Donation 5 Other Specify. 04-12-2007 Owners mills, mi) 21. Signature of Funeral Service Licensee aughor 8728 Liberty Road, Randallstown, MD 21133 23a. Part I. Inter the disease Physician or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Retween Onset and /Medical Death Fentanyl intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated certificate be executed Due to (or as a consequence of): events resulting in death) Last and transi Physician/Medical the attending physician ed for use as the burial -X UNPENDED 23a,PII,27,28a-f. , per FH. per ME. 2866. Box 68760, IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₫ ₫. 1 Yes 2 No 3 Probably 4 V Unknown Cirrhosis Completed Records, 24a. Was an 24b. Were autopsy findings available certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes ospital or Attending Physician: hours after death. 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one Be Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene After this 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural the f 5 Pending Yes 2X No Fnd 4/5/2007 Fnd 8:15 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 A Could not be within 24 hours at To the Funeral D determined (Specify) 4 found at home Homicide 4120 Fallstaff Rd. Baltimore, MD Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) April 6, 2007 O.C.M.E

D

State Registrar

31 Date filed (Month, Day, Year)

Jack Titus MD.

30. Name and address of p-11 on who completed cause of death (Item 23a)

32. Registrar's Signature

Deputy Chief Medical Examiner

nature

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Margaret T. Welsko 10 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Square aseda 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Year)
July 6, 1922 9. Birthplace (State or Foreign **Funeral** Days 1□M 2 💢 F Hours Months Min. Pennsylvania Director 207-03-5871 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f sh notified Mary land Baltimore | Baltimore 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be r 4919 Hazelwood Avenue 21206 **USA** Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int; If Item 27 is -arked other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 💢 No Specify Completed by 3 X Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Social Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be Jacob Benish Mary Mushinsky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Magdalene Benish/Sister 250 Maffett Street Plains, Pennsylvania 18705 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart Slovak 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4/13/07 Dallas Pennsylvania 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Leonard J. Ruck, Thc. 5305 Harford Road Baltimore Maryland mitua low 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Esophagus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-trai Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes **2**€ No 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760,

State Registrar

DHMH 17 Rev 1/2001

Yodit Negusse 9000 Franklin Square DR 31. Date filed (Month, Day, Year) APR 1 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32 Registrar's Signature

ORIGINAL

29d. Date signed (Month, Day, Year)

04-10-2007

Baltimore MARYland 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** April 9, 8:15 P. M Edward Wilson Whitehurst 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3344 Kensington Square Manchester Carroll If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 88 Yrs. XXM 2□F Director 217-01-7395 May 18, 1918 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits fshow be notified at 1XXYes 2 □ No Directo Maryland Carroll Manchester 28a-f 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō United States of America items 23a 3344 Kensington Square 21102 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1944– 12. Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examiner 1 ☐ Never Married 2 ☐ Married ò Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes XXNo Specify: þ 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. is marked other than 12th Contractor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hugh Whitehurst Bertha Funk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 i Bette Price (Daughter) 210 South Houcksville Road; Hampstead, Maryland tem 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 Deurial 2 Derenation 3 □ Removal from State April 13, 4 □ Donation 5 □ Other (Specify) 2007 Timonium, Maryland Signature of Full tals 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive; Manchester, Maryland 21102 4. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imperdiate Cause (Final disease or condition resulting in death) **Physician** Moseut Metustutu /Medical Due to (or as a consequence of) Examiner ASCUN_ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 □ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No certificate has b rector, page 2 sl 24a. Was an autopsy perform Hospital or Attending Physician: 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural
2 Accident 5 Pending investigation 1 🗌 Yes 2 □ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier Medical To the 29b. Signature and title of certiffe 29d. Date signed (Month, Day, Year) 30. Name and address of person who ompleted tem 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR11

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ORIGINAL

Ball !

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗀 🖯 🖯 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1534 PM Leon Marcellus Adkins Jr. Tarch 26 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Dorchester General ambridge Darches If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday. Days Hours 1**∑** M 2□ F 214-07-7011 1920 Marvland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Dorchester Cambridge 1 PYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 207 Dorchester Ave. 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) service manager car dealership 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Leon M. Adkins Cornelia Warst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth H. Adkins wife 207 Dorchester Ave., Cambridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Greenlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 3/29/07 Cambridge, MD 21. Signatury//Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Oranna Actely Dispase GOAGS

Examiner Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed neral Director: After this certific filled in by the funeral director. within 24 hours after To the Funeral Dire

Physician

/Medical

10a. State

MD

Examiner

Funeral

Director

Items 23s or 28s-f ehov

Director

Be Completed by Funeral

other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be flied within 72 hours after death with the 1. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28s-1 any injury or other traumatic event, the Madical Exemples.

Physician

/Medical

resuling in death)	Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. ————————————————————————————————————
that initiated events resulting in death) Last	c. Due to (or as a consequence of): d.
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown
Part II. Other significant condition Emple Somo Disease Tasaff Cient	23e. Did tobacco use contribute to the cause of death? 23e. Did tobacco use contribute to the cause of death? 23e. Did tobacco use contribute to the cause of death? 23e. Did tobacco use contribute to the cause of death? 23e. Did tobacco use contribute to the cause of death? 23e. Did tobacco use contribute to the cause of death? 23e. Did tobacco use contribute to the cause of death? 24e. Was an autopsy findings available prior to completion of pause of death? 24e. Was an autopsy performed? 25e. Did tobacco use contribute to the cause of death?
25. Was case referred to medical examiner?	Hospital: 26. Place of Death (Check only he)
1 Yes 2 Vo 27. Manner of Death 1 Statural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1
3 Suicide 6 Could no 4 Homicide determin	286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 C rtifying (Check only one)	Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Laminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and ottle of certifier	29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and wdress of person w

pleted cause of death (Item 23a) (Type, Print)

Bramble

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year BRENDA LYNN ALLEN 03724/2007 06:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 10755 GLENOLA ROAD CHESTERTOWN KENT 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) Date of Birth Birthplace (State or Foreign Country) 218-704291 1□M 2X)F 0770571958 48 Yrs. Director MD Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 27 is marked other then "naturel", or items 23a or 28a-f ehow traumatic event, the Mudical Examinar must be notified at 10d. Inside City Limits MD KENT Director CHESTERTOWN 1 TYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 EDGE OF TOWN DRIVE 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other then "nature!; or ite 1 ☐ Yes 2 🏹 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Completed by Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 Colfege (1-4or 5+) HOMEMAKER OWN HOME permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe eny Injury or other traumatic event, 2069. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM E. HARTMAN, SR. SYLVIA A. MCLAUGHLIN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM ALLEN/HUSBAND 108 EDGE OF TOWN DRIVE, CHESTERTOWN, MD 21620 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CRUMPTON CEMETERY 03/30/2007 CRUMPTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, PA
130 SPEER ROAD, CHESTERTOWN, MD 21620 wif 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf CARDIO PULHONARY Physician disease or condition resulting in death) /Medical Examiner of tongue to lung LETASTATIC CORCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 Yes 2 No 9 Unknown 9 LUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, TOBAGGO ABRELLE 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check only one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one | Check one Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 Yes 2 No Certification; To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer Division 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 🗋 Suicide 6 Coufd not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) - Cluab 123889 30. Name an Address of rson who completed cause of death (ftem 23a) (Type, Print) John C. ARRABAC AN, MS. 223 High Stuet, CHEStutain, Hed 21620 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Som & food Registrar MAR 2 9 2007

ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Vear CARL WAYNE ASBURY 4:30 A M 3 2007 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Manor Care Rossville Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5/17/1950 9. Birthplace (State or Foreign Days Hours 1XM 2□ F Director 217-50-2949 Maryland 56 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits or 28a-1 shov other traumatic event, the Medical Examiner must be notified at Director MD Harford Whiteford 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Iteme 23a 3924 Bay Road 21160 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 1970-72 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🂢 No Specify: White þ 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural;, amy injury or other traumatic event. The Medical Exagnos. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Ouarry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ervin Asburv Katherine Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana J. Asbury/Wife 3924 Bay Road, Whiteford, MD 21160 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Eagle Crematory 4/6/2007 Leola, PA 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA ant. Enter the disease, or comprications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** EKECLEROTIC ARDIOVASCULAR DISEACE disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): use as the burial-transit resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Wasan autopsy performed? Yes 2 No certificate 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 **N**0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Surcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completely the 29b. Signature and title of certifier 29c. License number D0060560 no completed cause of death (Item 23a) (Type, Print) 201 BACK RIVER NECK RD .#109 PANKAT KHETERIAL 32. legistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4:54 p M Evelyn Elizabeth Bovello March 24, 2007 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🗙 F **Director** March 1, 1924 238-26-9518 83 North Carolina Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐Yes 2 No Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 2346 Glenmont Circle, Apt. #112 20902 U.S.A. "natural", or items 23a hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates; 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: ş 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) the 12 **Executive Secretary** National Rifle Association 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental ည Moses Herman Denning Madell Chadwick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Is r Ronald G. Bovello - Son 2346 Glenmont Circle, Apt. #112, Wheaton, Maryland 20902 If item 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parklawn Memorial Park & 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If iter
any Injury or ott 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Menorah Gardens 3/30/2007 Rockville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Physician/Medical as the t **∤F FEMALE** for use If yes, outcome pf pregnancy 1□Live birth 2□Feta! death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by sign Congestive Heart Failure 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Renal Failure page 2 performed? Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 N Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending 1 X Natural investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide 1 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

5 To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After

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EVENN

10 State

Registrar

29b. Signature and title of certifier

Steven Wilks, M.D., 9901 Medical Center Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) MAR 28

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



5. wilks

29c, License number

D63195

29d. Date signed (Month, Day, Year)

March 24, 2007

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Grace Balla March 27, 2007 150 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SALISBURY REHAB & NURSING CENTER SALISBURY, MD. 21804 WICOMICO If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 7/29/J.916 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🖺 F Days Hours 214-10-6330 90 Director Michigan Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or itams 23a or 28a-1 show injury or other traumatic evant, the Medical Exar it are must be motified at 10d. Inside City Limits 1X Yes 2 □ No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or itams 23a or 114 Tilghman St. 21804 HSA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ☐ Yes 2 🔀 No f Yes. Give 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: white Completed by If Yes, Give Year or Dates: Specify: 3 X Widowed 4 □ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. om 27 ie marked other than Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Shirt Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ernest A. Yerkie Bertha Boeck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 ie Bill L. Marsey/grandson 10303 Riverton Rd., Mardela Springs, MD 21837 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages ' 1 ☐ Burial 2 KI Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Salisbury Crematory 3/28/07 Salisbury, MD 21. Supature of Funeral Service Licensee Name and Address of Facility Home Professional Association any 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. 501 Snow Hill Rd., Salisbury, MD 21804 Interval Between Onset and Death Immediate Cause (Final Physician Ceretis. disease or condition resulting in death) 2700 /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last 40017 1 Due to Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit 4000 Due to (or as a consequence Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months?
1 Yes 2 No Year 4☐Pregnant at time of death Month Day 5 Other (specify) 9 Unknown 9 ☐ Unknown δ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 1 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Tes 1 🗌 Yes 2 No 2440 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA his 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death thours after death uneral Director; 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours To the Funeral 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM ROBINS, M.D. 200 CIVIC AVE., SALISBURY, MD.

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Baltimore,

Box 68760. P.0. Division of Vital Records. 07-02339 Lester C. Barrett Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Ce	rtificate of D	eath	Re	Reg. No.		
Physici Medical Exam		1. Decedent's Name (First, Midd estev	Coreland	Barr	e†+	2. Date of Deat Month March 26,	Day Year 2007	3. Time of Death 1754 hrs	
		4a. Facility Name (if not institution Chester River Hospita			City, Town, or Location o Chestertown	f Death	4c. County of Deat Kent	th	
Funeral Director		5. Social Security Number 213-60-7547	6. Sex 7. Age (In yrs. I	· · ·	f Under 1 Year If Under Months Days Hours	Min. May	th(MM/DD/YYYY) 9. Bi Forei 2 <i>9, 1952</i>		
Baltimore, MD 21215-0036 Semit. Pages I and 2 should be filed within 72 hours after death with the Maryland bepartment of Felath and Memal Hygiene. Might are the filem 27 is marked other than "natural", or items 23a or 28a-f show any nijury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10e. Street and Number H/G Calver 11. Marital Status 1 Never Married 2 M. 3 Widowed 4 Div 15. Decedent's Education (Special Secondary (0-12) 17. Father's Name (First, Middle, Cerrant's Name/Relations) 19a. Informant's Name/Relations Savey Ba 20a. Method of Disposition	nt Street 12. Was Decedent Ever in U Armed Forces? 1 V Yes 2 No orced If Yes, Give Year 1972 - 19 cify only highest grade completed) College (1-4 or 5+) Last) Opeland Bar hip (Type, Print) Lyrett Removal from State 20b. 1	If Yes, 1 Ye 16a. Decedent's Uduring most of during most of the during most of the first term of the first term of the during and during Add the Company of the first term o	accedent of Hispanic Original Specify Cuban, Mexican, Secretary Cuban, Mexican, Secretary Cuban, Mexican, Secretary Constitution (Give keeps of working life, DO NOT to the secretary Constitution of the secretary Cons	in? (Specify Yes or No-Puerto Rican, etc.) ind of work done use retired) Some (First, Middle, More or Rural Route Num of Chestert	White, etc. Specify: B 16b. Kind of Business Transpo faiden Surname) Dod ber, City or Town, State	10d. Inside City Limits 1 Pyes 2 No untry? rican Indian, Black, /a C K /Industry r +a +i on de, Zip Code) /and 2 16 2 0 r Town, State	
Physician /Medical Examiner	Examiner	04 07 15 10 :	Licensee complications that redused the death on each line. a. Hypertensive Atheroscl Due to (or as a consequence or b. Due to (or as a consequence or c.) Due to (or as a consequence or d.)	22. Name He N 5 10 1. Do not enter the m lerotic Cardiova ff):	RY FUN EVEL I WOSHINGTON lode of dying, such as ca	Jome, P. A. J. Str. Camb diac or respiratory arre	ridge, Mi st, shock, of heart	D: 2/6/3 Approximate Interval Between Onset and Death	
P.O. Box 68 ss that the death certi gned by the attending		IF FEMALE: 23b. Was decedent pregnant in th past 12 months? 1 Yes 2 No 9 Unk	AMENDED 23c. If yes, outcome of pregree 1 Live birth 4 Pregnant at time of de 9 Unknown ons contributing to death but not re	2 Fetal death 5 Other	(Specify)	t I. 23e. Did tol	bacco use contribute to 2 No 3 Prol 24b. Were au prior to 6	Day Year the cause of death?	
1 of Vital Records, ling Physician: The law require After this certificate has been si funeral director, page 2 should b	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death	Henritals	ER/Outpatient 3		1 Ves 2 Check only one) Nursing Home 5 F			
Division c pital or Attending ours after death. teral Director: Aft	Certification:	1 Natural 5 Pend Invest Suicide 6 Could	(Month, Day, Year)		1 Yes 2 1	No	treet and Number or Ru	ural Route Number, City	
Divis To the Hospital or A within 24 hours after To the Funeral Dire	Medical C	29a. Certifier (Check only 1 Certifying Ph	nysician: To the best of my knowledg						
To To	Me	29b. Signature and title of certifie	and manner stated	· · · · · · · · · · · · · · · · · · ·	29c. License number O.C.M.E.		29d. Date signed (Mo	nth, Day, Year)	
	ł		who completed cause of death (Item		Baltimore, MD 2120				
St Regis	ate	31. Date filed (Month PAR ear)	9 2007 32. Registrar's Signatu		B.				

			For State Registrar	State of M	aryland / [rtment of H		nd Me		giene	UTU I	11401
17	Ca. 110		1. Decedent's Name (First, Middle, Las	t)					2	. Date of Dea	th		3. Time of Death
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	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	or Location of D	Death		4c. C	ounty of Death	
h			Wilson Health C	are Cente:	r		Gai	thersbu	ırg			Montgom	erv
Part	Funeral		Social Security Number 6. Security Number		e (In yrs. last bii		If Under 1 Year Months Days	If Under 24		. Date of Birth (Month, Day	1	9. Birthp	lace (State or Foreign
- 8	Director		409-12-8303	□M 212 F	87	Yrs.		1.00.0	D	ec. 19	, 19	19 Teni	nessee
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Loc	ation					-	0d. Inside City Limits
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	he N	Director	Maryland Frederic	ск	M	t. E	Airy						
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Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, its Medical Exercites must be reditied at	To B	James M. Butle	r				Sara	. Но1	1 Bell			
3	shou nd M mar	-	19a. Informant's Name/Relationship (7		19b	. Mailing	g Address (Street				_	own, State, Zip	Code)
	nd 2 lith a 27 is r trai		James M. Bradley	/ Son			Bill's						•
ē,	F Hearl Hearl		20a. Method of Disposition		20b. Place of	Dispos	ition (Name of		Date			tion - City or To	
altimore,	Pages nent of int; if it iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			-	atory or other place Memorial	· i	Mar	ch 2007	D1	.211. 1	41
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Ba	permit. Pages 1 Department of H Important; If Itel any Injury or ott		4097	6									land 21771
\$	4 /		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused	the death. Do r							y, mary.	Approximate
			shock, or heart failure. List only of	one cause on each li	ne.		,	3,					Interval Between Onset and Death
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ň	death atte	cla	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death time of death		Ectopic pregnancy Other (specify)	1			200		Day Y <i>e</i> ar
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Division of	or Attencater death Director: in by the	Certification:	4 Homicide determined	28e. Place of fnit building, et	c. (Specify)	rm, stre	et, factory, office		281	City or Town		Number or Rura	Route Number,
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(×		30. Name and address werson who of MERLYN VEM	ompleted cause of d	elt (Item 23a) (Туре Р	rint)	ALC	<	NUC	0	100 101	4. Mn
	St.		31. Date filed (Month, Day, Year)			0	LUCUH	1 / WI	1	LVE		7100	> 1.10,
	Sta Registr		MAR 2 9 20	n7 32. jegistra	ar's Signature	1							
Drin			MAR 2 2 20	J. J. ROBLA	as D.	aires.							
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 11:15P M 26, 2007 <u>Marian Helenetta Coblentz Boyer</u> Mar. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Homewood at Crumalnd Farms Frederick Frederick 8. Date of Birth Nov. 6, 1920 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M XXX 86 Months Days Hours Min Yrs. "MD 217-18-8504 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits Frederick MD 1 ☐ Yes 2x No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7407 Willow Rd. 21702 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Specify: Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter Boyer Coblentz Mary Beachley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jo Ann Poffinberger (Daughter) 4322 Cherry Ln., Jefferson, MD 21755 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
4 Doyation 5 Other (Special) Lutheran cemetery 3/30/2007 Middletown, MD 4 Dogation ure of F neral Se vice Lice Donald B. Thompson Funeral Home P. O. Box 18, Middletown, MD 21769 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or rear failure. List only one cause on each line. Immediate Cause (Final ARTURY DISENTE ORONAR disease or condition resulting in death) 3 months Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Tricuspid 21 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

/Medical Examiner be executed Division of Vital Records, P.O. Box 68760

burial-transit attending physicien for use as the buria his After f Hospitel or Attending death. To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu

Physician

/Medical

Examiner

Funeral

Director

in than "natural", or iteme 23a or 28a-f ehow The Medical Exeminer must be notified at

permit. Pages 1 and 2 should be filed within 72 t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other treumatic event, the Madical Once.

Physician

Direct

Completed

the Maryland

death

hours affer

Saltimore, Maryland 21215-0036

ğ Completed

Examine Physician/Medical

Certification:

Medical

25. Was case referred to dical examiner? 1 Yes 2 No 27. Manne of Death

4 T Homicide

(Check only one)

1 Natural 2 Accident 3 Suicide

5 Pending investigation 6 Could not be determined

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

D20488

1 □ Yes 2 □ No

3/29/07

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Type. Print) S. Church St. Middletown, U.D.

State Registrar

31. Date filed (Month, Day, Year) 2007 32. A strar's Signature

28b. Time of

28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)

Injury

State of Maryland / Department of Health and Mental Hygiene

1- State Registrar Amend Line 31 per Health Dept. KG Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 WILLAMINA BYRNE **2**0 MARCH 9:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CORSICA HILLS NURSING HOME CENTREVILLE **QUEEN ANNE** If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours 1 M 2 X F 86 Yrs. Director 407-18-3813 1920 IOWA Usual Residence of Decedent with the Maryland show 10b. County 10c. City. Town or Location 10d. Inside City Limits itam 27 is markad othar than "natural", or Itams 23a or 28a-f shov other traumatic evant. If w Medical Exerninar must be notified at Director 1 Yes 2 XX **OUEEN ANNE** STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 11 MARINERS WAY 21666 death Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 is marked other than any injury or other traumatic event, Itam Ma Elementary/Secondary (0-12) College (1-4or 5+) 12 -O-RECEPTIONIST RADIO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) LOUISE WILLIAM KRULL LASWELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 111 S. LIBERTY ST., #4, CENTREVILLE, MD 21617 JOHN S. BYRNE/ SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) ST. PETER'S CEMETERY 3-23-2007 QUEENSTOWN, MD 21. Signatur of Fineral Service Ligensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Approximate Interval Between Immediate Cause (Final Onset and Death Priysician Alzkermons disease or condition resulting in death) neens /Medical Due to (as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical the as t IF FEMALE: esn 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown þ been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 Yes Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in hours. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Internans Lane, Easton, MD 21601 mowless 610 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/200

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State of Maryland / Department of Health and Mental Hygiené UU 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 2105 31 2007 /Medical Alice Shively Bunce 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Kent Heron Point Chestertown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-30-1911 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 ☐ F Min 96 Yrs. Kyoto, Japan Director 561-82-1334 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or items 22s ---- any injury or other treumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MDChestertown Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 501 East Campus #2034 Heron Point 21620 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No þ 3 ☐ Widowed 4 ☐ Divorced Specify: white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Renjamin Franklin Shively Grace Ressler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allen, MD 21810 PO Box 1079 William Kenneth Bunce/husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Chester, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fellows, Helfenbein & Newnam Chestertown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE ALZHEIMERS DEMENTIF /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 SNo
9 Unknown been signed by the atternment of the better should be detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury Natural 5 Pending within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Speer Rd Chestertown Noble telen A MI 122 31. Date filed (Month, Day, Year) 32. Regitrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU/ 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CYNTHIA LOUISE BRENSON 8.44.4M MARCH 26 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HANFORD MEMORIAC HOSPITAL HARFORD HAURE DE GRACE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🛛 F Yrs. 52 Director 559-96-6041 CALIFORNIA Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City. Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examinar must be notified at 1 XYes 2 No Directo MARYLAND **HARFORD ABERDEEN** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 42 E. BEL AIR AVENUE, APT 7 21001 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: UNKNOWN Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 1 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) other than Colfege (1-4or 5+) FOOD SERVICE 12 NURSING HOME Department of Health and Mental important: If Itam 27 is any injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be UNKNOWN 2 UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DANIEL BRENSON / SON 20 ABERDEEN AVENUE, ABERDEEN, MARYLAND 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) R.A. FERRIS & CO. INC 3/29/07 WEST CHESTER, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A. - disa Scott-Coleman 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line. MD 21078 Approximate Interval Between Onset and Death Immediate Cause (Finaf disease or condition resulting in death) **Physician** METASTATIC ESOPHAGEAL CANCER 8 MONTHS /Medical Due to (or as a consequence of): Examiner dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): attending physician to use as the buria Physician/Medical 8 *IF FEMALE:* 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetaf death 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a Id be detached t 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has tirector, page 2 s autopsy performed? 1 ☐ Yes 25 No 1☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1. Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Medical Certification; 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours atter of To the Funeral Direct completely tilled in by 4 T Homicide

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

2+IVA

State Registrar

29a. Certifier

31. Date filed (Month, Day, Year) MAR 2 9 2

29b. Signature and title of certifier

29c. License number 21338

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

71

MARCH. 26.2007

HAURO de GRACE

SWEATTEAN

HARFOLD DENTOLITE 1805 PITAL

\$2. Registrar's Signature

3. Time of Death

4:45 P. M

1 Yes 2 No

Year

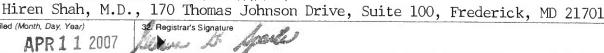
29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 32 Registrar's Signature APR 1 1 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

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	and		Usual Residence of 10a. State	Decedent 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limits
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Baltimore,	of He	9	20a. Method of Disp		Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place	ce)	Date	20c. Location	- City or To	wn, State
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DHMH 17 Rev 1/2001

		1 - For State Registrar	State of	Maryland / De C	partment of F ertificate of			giene	07	11465
B		1. Decedent's Name (First, Middle,	_ast)				2. Date of Dea	ith Day	Voor	3. Time of Death
Physic /Med		GEORGE ROBERT	COLE				MARCH		Year 2007	10:10AM
Exami		4a. Facility Name (If not institution, g		oer)	4b. City, Town, o		eath	4c. County	of Death	
		700 PORT ST., A				STON			TALB	
Funeral Director		212-03-5855	Sex 7. 1 ▼ M 2 □ F	Age (In yrs. last birthda 88 Yrs	Months Days	If Under 24 H	8. Date of Birth	7 19 18		Ace (State or Foreig
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10	Od. Inside City Limits
death with the Maryland rms 23a or 28e-f ehow rmust be notified at	ģ	MD. TALBO	T		STON					Yes 2 No
h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Coun	try?
th wit	a D	700 PORT STREET	APT. # 20	6	21	601		U.S	.A.	
r dea	Funeral	11. Marital Status	12. Was Deced		Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or No-	14. Rac	e - America	
36 safte	by Fu	1 Never Married 2 Married	If Yes, Give	ADMV	1 ☐ Yes 2 No	Specify:			WHIT	
5-0036 72 hours after natural, or ite	ed b	3 Widowed 4 Divorced 15. Decedent's	Year or Date		cedent's Usual Occup	ation		16b. Kind of B		
15 10 10 10 10 10 10 10 10 10 10 10 10 10	Completed	(Specify only highest	grade completed)	(G	ive kind of work done DO NOT use retired	during most of	working	160. Kirid of bi	u3111033/1110	ustry
2121 ad within rgiene.	E O	Elementary/Secondary (0-12)	College (1-4	S ¹	TATE POLIC	E OFFIC	ER	LAW ENFORCEMENT		
nd 2 be filed tal Hygi d other	Be	17. Father's Name (First, Middle, La	st)			18. Mother's I	Name (First, Middle,	Maiden Suman	ne)	
Van Ment Ment arked	2	GEORGE W. COLE				PEA	RL E. 1	MOFFAT		
and and seminary		19a, Informant's Name/Relationship	(Type, Print)		ailing Address (Street					Code)
9, N lealth m 27		ROBERT A. COLE/	SON		3 LARRIKEE's position (Name of	T CT. P	100			
Baltimore, IV permit. Pages 1 end Department of Health Important: If item 27 any injury or other 200ce.		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3		ate cemetery, o	rematory or other place	· -	Date 17-07	20c. Location -		
Iting it. Pa rtmer rtent njury		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lice			REMATION C	1		STEVENS		
Baltimo permit. Pag Department Important: If any injury or		Juseph m. D.	transki !	C.F.SP.	PELLOWS A HAR	RISON S	TREET EAS	ron, MD		
Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	aa	Preuma		ng, such as card	fiac or respiratory an	rest,		Approximate Interval Between Onset and Death / week
cate be executed EX physicien and III in the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Chra	as a consequence of): as a consequence of): as a consequence of):	ructua	Pulmo	enary d	VEIR		1990-11
death certifi death certifi e ettending	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 Fetal death nt at time of death	3□Ectopic pregnancy 5□ Other (specify) _	/			te of delive	ry Day Year
thet the	h h	Part II. Other significant conditions	contributing to deal	th but not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use cont	ribute to the	e cause of death?
dS Puires Id be	d by						1 🗆 Y	es 2 🗆 No	3 Proba	ably 4 Unknow
Hecords, The law requires to the has been signed age 2 should be	Completed						24a. Was a	an 24b. '	Were autor	osy findings availabl
The lav	Ë						- autop	sy med?	prior to con death?	npletion of cause of
Tan	0	25. Was case referred to medical				26. Place of f	1 □ Yes Death (Check only or		1 □ Yes	2 NO
OT VITAL Physician: T r this certificet ral director, p	ToB	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inp	atient 2 ER/Outpat	ient 3 DOA Oth	00	g Home 5 ☐ Resid		er (Specify	ASSISTED
ng Pt fter th		27. Manner of Death 1 Sanatural 5 ☐ Pending	28a. Date of (Month,	Injury 28b. Time Day Year) Injur		y at k?	28d. Describe h	ow intury occur	red	LIVING
DIVISION OT VITA I or Attending Physician: after death. Director: After this certific d in by the funeral director.	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of	Injury - At home, farm,	M 1 🗆	Yes 2 □ No	28f. Location (S City or Tow	treet and Numb	er or Rural	Route Number,
DIVI To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by										
24 hc 24 hc Fun	Medical	(Check only 2 Medical Ex	nysicien: 10 the basi aminer: On the basi and manne	est of my knowledge, de is of examination and/or r stated.	investigation, in my o	ne, date and pla pinion, death o	ace, and due to the o courred at the time, o	ause(s) and ma late and ptace,	anner as sta and due to	ated. the cause(s)
To the vithin To the complex c	Me	29b. Signature and title of certifier			29c. Licens	e number	2	29d. Date signe	d (Month, L	Day, Year)
- > + 0			20	MD	000	5113	2	3-1	(-3	7
- 10		30. Name and address of person wh	o completed cause	of death (Item 23a) (Typ	e, Print)					
STVA		JORGE H. ABREGO	MD 598 (CYNWOOD DRI	VE, SUITE	104 EAS	TON, MD.	21601		
St	ate	MAR filed (Month Day, Year)	32. Reg	istrar's Signature			<u> </u>			

Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer
(0+1)	S Regis

		For State Registrar	State	of Marylan	-	artment of H		and M		giene Reg. No.	007	Odds standard	155
		1. Decedent's Name (First, Mi	ddle, Last)						2. Date of De. Month	ath Day	Year	3. Time of	Death
Physici /Medic			Arthur B.	Coates	Jr.				March	26	2007	8:58	РМ
Examin	_	4a. Facility Name (If not institu		ımber)		4b. City, Town, or	Location o	f Death		4c. Cou	inty of Death		
	\$	3085 Bethany				Ellicot					oward		
Funeral		5. Social Security Number	6. Sex 1 ★ M 2 ☐ F	7. Age (In yrs.	last birthday Yrs.	Months Days	If Under 2 Hours	Min.	8. Date of Birl (Month, Da	y, Year)	Cou	place (State on try)	
Director		233 28 8274 Usual Residence of Decedent		84	115.				Sept 1	2,1922	2 Wes	t Virg	inia
and www.t		10a. State 10b. Cou	nty	10c. Cit	ty, Town or L	ocation						10d. Inside C	ity Limits
Manyl f sho ed a	ō	MD	3	777	172	L Oiles					j	1 ☐ Yes	2 X No
the N 28a-	Director	MD How 10e. Street and Number	ard		LIICOT	t City 10f. Zip Code				10g. Citizen	of What Cou	intry?	
with 3a or 1 be	٥	3085 Bethany	T.ano			2104	2			Unit	ted Sta	ates	
ns 23 mus	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Decedent of H		gin? (Spe	ecify Yes or No		Race - Amer		
r iter		1 Never Married 2 N	Armed F larried 1∑ Yes	2 □ No				i, Puerto	Rican, etc.)		Black, White	, etc.	
urs arali, o	by	3 ₩ Widowed 4 Divor	ed If Yes, G Year or I	odes:unkno	own	1 ☐ Yes 2 🙀 No	Specify:			Spi	ecify: W	hite	
72 hc natui lical	Completed	15. Dece	dent's Education)		edent's Usual Occup		t of worki	na	16b. Kind o	f Business/I	ndustry	
ithin nan "	du	Elementary/Secondary (0-1		(1-4or 5+)	life.	DO NOT use retired	1)		3	_			
lygiel her tl		12	H- 1 - 1)		S	ystems Ana	_	ala Blassa	(First, Middle,			vernme	nt
be findal H	Be	17. Father's Name (First, Mide Arthur B. Coa							Grounds		name)		
d Mel nark	P L	19a. Informant's Name/Relati			10h Mail	ing Address (Street					uun Ctoto 7	in Codo)	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.		Monique Summe		r		Cascades						. ,	
of Hei		20a. Method of Disposition	0 TP		Place of Disp	osition (Name of ematory or other place	ce)		Date	20c. Locati	on - City or T	own, State	
tment tant: If		1	r (Specify)	Bo		oro Cemete			-2007		esboro	•	
permit Depar Impor any in		21. Signature of Funeral Serv	ice Licensee) M010	044	2. Name and Address	ss of Facility Columb	^y Hari bia_1	ry H. W Pike El	itzke' licott	s Fam:	ily FH , MD 2:	Inc. 1043
		23a. Part1. Enter the disease shock, or heart failure.	, or complications hat list only one cause on	caused the deat	th. Do not er	nter the mode of dyin	ng, such as	cardiac o	or respiratory a	rrest,		Approxima Interval Be	tween
Physician		Immediate Cause (Final disease or condition	Pro	state	CAP	fe 7111	MSE	70				Onset and	
/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):			-					
Examine	_	Sequentially list conditions,	b	/								· · · · · · ·	
led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	- Due to	(or as a conseq	querice or):								
be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c	(or as a conseq	quence of):								
siciar buria	ical												
ficate phys			d										
certi nding use a	Ž	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregna						23d.	Date of deli	verv	
death atte	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg	birth 2□Feta µnant at time of c		□Ectopic pregnancy □ Other <i>(specify)</i> _	<i>'</i>				Month	Day	Year
t the oy the archer	hys	9 ☐ Unknown	9∐Unk	nown					-				
s thai	by P	Part II. Other significant con-	ditions contributing to			1 1			23e. Did t	obacco use	contribute to	the cause of	death?
quire en sig uld b	q pe	, GALH	Henry	Luija	192	Dinbet	67		10	Yes 2□N	lo 3∏Pro	bably 4	Unknown
aw re s bee	olete	millifus							24a. Was		4b. Were au	opsy findings	available
The late ha	Completed		1						autoj perfo 1⊟ Yes	psy ormed? 2⊠No	death?	ompletion of a	ause of
an: rtifica tor, p	Be C	25. Was case referred to med	lical				26. Place	of Death	(Check only o				
nysic iis ce direc	To E	examiner? 1	Hospital: 1	Inpatient 2] ER/Outpatie	nt 3□ DOA Oth	er: 4 □ Nu	rsing Ho	me 5□Resi	dence 6	Other (Spec	wasst.	livg.
ng PI fter th neral	nc.	27. Manner of Death 1 X Natural 5 ☐ Per	28a. Date (Mo	e of Injury nth, Day Year)	28b. Time Injury	of 28c. Injur Wor	y at k?		28d. Describe	how injury oc	curred		
endir ath. or: Ai	atic	2 ☐ Accidentinve	estigation			M 1 🗆	Yes 2□I	No					
r Att	Certification:		uld not be ermined 28e. Plac	e of injury - At h	ome, farm, s	treet, factory, office		1	28f. Location (: City or Tox	Street and No wn, State)	umber or Ru	ral Route Nur	nber,
oital o													
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		fying Physician: To the cal Examiner: On the and ma										s)
To the To the To the Complex c	ž	29b. Signature and title of cer	tifier 1	V . 1		29c. Licens				29d. Date si	gned (Month	, Day, Year)	
		you	(15 . / / / /)	1/1	M.D.	$\Box D = 3$	305	73		Marc	ch 27,	2007	
		30. Name and address of per-	on who completed cau	ise of death (Iter	// [Print) Co	Ival	hia	MD.	2104	4 1-	TM.	Sord
Sta	ite	31. Date filed (Month, Day, Ye		Figistrar's Signa	ature		(-) -		1.0		/U/	V - 1 1 ((147 LX
Registr		MAR 2	9 2007	Keese.	N L	berte							
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			For State	State of Ma		artment of Healt			- 20	07	111.67
			Registrar Certificate of Death					2. Date of Death 3. Time of Death			
Physiciar /Medica			JON		CROCKETT			Month MARCH	25, 2	Year 2007	6:18 P M
Examine		er	4a. Facility Name (If not institution,	4b. City, Town, or Locati	1	4c. County of Death					
Funeral					e (In yrs. last birthday)	SILVER SPRING			1	MONTGOMERY 9. Birthplace (State or Foreign Country)	
Di	rector		578-46-0307 Usual Residence of Decedent	1□M 2 X F	74 Yrs.	World's Days Hou		(Month, Day JULY 15			ORADO
yland	at		10a. State 10b. County		10c. City, Town or Lo	cation				1	0d. Inside City Limits
e Mar	a-f st tiffed	Director	MD. PRINCE GEORGES BELTSVILLE								1∭XYes 2 □ No
with th	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. A file m 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		10e. Street and Number			10f. Zip Code	0g. Citizen of		itry?		
death		Funeral	13210 INGLE	12. Was Decedent B	Ever in U.S. 13.1	Vas Decedent of Hispanic f Yes, specify Cuban, Mex		ifv Yes or No-		S.A.	an Indian,
36 s after o			1 □ Never Married 2 □ Married	If Yes, Give	10	f Yes, specify Cuban, Mex 1 □ Yes 2 ∑ No <i>Spe</i> c		lican, etc.)	Blac Specif	ck, White,	etc.
21215-0036 ed within 72 hours af giene.		ed by	3 Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:		dent's Usual Occupation			16b. Kind of B	WH.	LTE Sustry
215 Trin 72 e.		Completed	(Specify only highest grade completed) (Give kind of work done during most of work during most of work done during most o				most of working	ding			
d 21 filed wit Hygien	ner th	To Be Con	12			HOMEMAKER)ME	
and d be fi	intal H ed oth ed oth		17. Father's Name (First, Middle, La	UNK.		18. M			Maiden Surnar	,	
Maryland id 2 should be file tth and Mental Hy	s mar umati		19a. Informant's Name/Relationship	(Type. Print)	19b. Mailir	ig Address (Street and Nu	MARY Imber or Rural	LUCI Route Number		IORSE State, Zip	Code)
and 2	n 27 is ner tra		PAUL CROCKET	r/son		O INGLESIDE	DR., E	BELTSVI	LLE, MD	207	705
altimore, mit. Pages 1 ar	or oth		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3			natory or other place)	Da	ite	20c. Location -	- City or To	wn, State
Baltimo permit. Pag Department	Important: I any injury o once.		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice				3-28-2		RIVERD		
Balti permit. Departr	and and and		21. Signature of Funeral Service Licensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737								
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Approximate Interval Between								
	sician		Immediate Cause (Final disease or condition resulting in death)	-	PULMONARY 1	EMBOLISM					Onset and Death
0.00	/Medical xaminer		1	a consequence of):							
	=	ner	Sequentially list conditions, if any, leading to immediate cause. Erriter Underlying Cause (Disease or injury	a consequence of):							
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8760, sate be ex		dical E		Due to (or as a	a consequence of):						
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Box eath cer	attending p for use as	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		3 □Ectopic pregnancy			23d. Date of delivery Month Day Year			
. the de .	by the a	Physician/Me	1 ☐ Yes 2 🕱 No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown					- Month			Day Year
s that	ned by e deta	by Ph	Part II. Other significant conditions	s contributing to death bu	it not resulting in the ur	nderlying cause given in Pa	art I.	23e. Did tobacco use contribute to the cause of death?			
Records, he law requires the	/sician: The law requires that the death certificate be executed is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	ed b	MORBID OBESITY					1 ☐ Yes 2 📉 No 3 🗀 Pr			ably 4 □Unknown
e law r		Completed	DIABETES					24a. Was a	sy	24b. Were autopsy findings available prior to completion of cause of	
		o Be Con	OF Management and the second and the						2 X No	death? 1 🗌 Yes	2□ No
VII			25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specific)								d)
O E E	Arter this funeral dii	ii.	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred								<u>//</u>
DIVISION OF all or Attending Phy after death.	the fu	catic	2 Accident investigation M 1 Yes 2 No								
DIV after of	after de Direct J in by t	Certification:	3 Suicide 4 Homicide 4 Homicide 5 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							I Route Number,	
DIVISION Or VITA the Hospital or Attending Physician:	unera		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
the H	within 24 hours at To the Funeral C completely filled i	Medical	one) and manner stated.								
Towith	2 8	-	D0053235				29d. Date signed (Month, Day, Year)				
0 (7)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							l .	
10	/			HILL, M.D.	13635 E	SALTIMORE AV	E., LAU	REL, M	2070	7	
F	Stat Registra		31. Date filed (Month, Day, Year) MAR 2 8 2007	32. Registra	's Signal						
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		1 - For Amend Line 31 Registrar	State of M per Health I	aryland / De ept kG C	partment of I ertificate of	lealth and i Death		giene Reg. No.	07	11468	
Dhyo	ician	1. Decedent's Name (First, Middle, Last)						nth Day	Year	3. Time of Death	
Phys /Me	dical	WILLIAM RAY COURSEY					MARCH	1 ⁷ ,	2007	11:37 A ^M	
Exan	niner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death						4c. County of Death			
		CORSICA HILLS NUE	RSING HOME		CENTREV	ILLE		QUEEN	ANNE'	S	
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 № 2 □ F 83 Yrs.			Months Days	Months Days Hours Min (Monti			f Birth b, Day, Year) 9. Birthplace (State or Foreign Country) MARYLAND		
pu s		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Lagation				140	t tarify on them.	
anyla eho	1		-						100	Inside City Limits	
he N	Director	MARYLAND QUEEN A	NNE'S	STEVENS							
Mith 1		10e. Street and Number			10f. Zip Code				What Country	y?	
e 23	- a	200 TERRAPIN GROVE APT 103 11. Marital Status 12. Was Decedent Ever in U.S. 13			21666 Was Decedent of Hispanic Origin? (Specify Yes or N			USA 14. Race - American Indian,			
ore, Maryland 21215-0036 s. 1 and 2 should be filed within 72 hours after death with the Maryland of Heelth and Mental Hygiene. Item 27 is marked other then "neturel", or Iteme 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status	Armed Forces	?	 Was Decedent of I If Yes, specify Cub 	Hispanic Origin? (Sp Jan, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ce - Americar ck, White, et		
rs aff	5	1 Never Married 2 M Married 1 MYes 2 No If Yes, Give Year or Dates: 1943-1946			1 ☐ Yes 2 X No Specify:			Specify: WHITE			
21215-0036 d within 72 hours aff giene. or then "neturel", or the Medical Exem	8						16b. Kind of Business/Industry				
1 27 of 1 05	Completed	(Specify only highest grade completed) (Give kind of work done during most of work)					king	ng			
	E	Elementary/Secondary (0-12) College (1-4or 5+) 10 MASON						CONSTRUCTION			
Hygied A.		17. Father's Name (First, Middle, Last	"			18. Mother's Nam	ne (First, Middle,				
Maryland d 2 should be file th and Mental Hy it is marked oth traumatic event	To Be	RAYMOND FORD COUR	RSEY			ELSIE D.	HENDERS	ON			
aryla should nd Men marke	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	uling Address (Street	I			State Zin C	ode)	
and 2: and 2: seelth at n 27 is	10	LEWANNA JANE COUR						, - ,		ARYLAND 2166	
Te, N 1 and 2 Heelth tem 27		20a. Method of Disposition	DLI/WILL	20b. Place of Dis	position (Name of			20c. Location			
Baltimore, permit. Pages 1 at Department of Hee Important: if item eny injury or othe		4 □ Donation 5 □ Other (Special	20a. Method of Disposition 1 \(\sum{Buriar} \) 2 \(\subseteq \text{Cremation} \) 3 \(\subseteq \text{Removal from State} \) 4 \(\subseteq \text{Donation} \) 5 \(\subseteq \text{Other (Specify)} \) 20b. Place of Disposition (Name of cemetary, crematory or other place) STEVENSVILLE CEMETERY 20c. Location - City or Town, State 20c. Location - City or Town, State STEVENSVILLE, MARYLAND								
Dermi Depa Impo		21. Signature of Fineral Service Lice	+ too		FELLOWS, HE 106 SHAMRO	LFENBEIN OCK_ROAD,	AND NEWI CHESTER	NAM FUN MARYI	ERAL H	OME, P.A. 1619	
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18760, cate be executed physicien and the burial-transit	Examin	cause. Enter Underlying Cause (Diseese or injury that initiated events									
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68 tifical	ed										
P.O. BOX 6 et the death certific by the attending parached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant				23d. Date of delivery					
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oche the	hys	9 Unknown									
_ 5 5 5	by P	Part II. Dther significant conditions			underlying cause giv	ren in Part I.	23e. Did tol	bacco use cont	acco use contribute to the cause of death?		
rds quire sign		A13 heimer's domentia					1 ☐ Yes 2 ☐ No 3 € Probably 4 ☐ Unknown			ly 4 □Unknown	
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The lav	료						24a. Was an autopsy performed? 1 Yes 255No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No			letion of cause of	
VITAL siclen: T certificet rector, pa		A- 111								□ No	
Of Vita Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpati		_ Ott	. /	th Check only on	-			
Phys rthis rat did	 -	1 Yes No 27. Manper of Death	1 _ Inpati		ent 3 DOA	4/3 Nursing Ho	ome 5 ☐ Reside				
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DIVISION for Attending after death. Director: Afte	Certification:	4 Homicide determined	building, el	c. (Specify)	street, ractory, office		28f. Location (Si City or Town	n, State)	er or Hural H	ioute Number,	
DIVI Nospital or At 24 hours after of Funeral Directors in by		29a. Certifier 29a. Certifier Check cut.									
DIV To the Hospital or A within 24 hours after To the Funeral Dire completely filled in by	Medical	(C) Medical Examiser: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the courselob									
To the within To the Compl	Ž	29b. Signature and title of certifies 29c. License number 29d. Date signed (Month						d (Month, Da	y, Year)		
	1	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed use of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Register's Signature 33. Register's Signature 34. Aparth									
		30. Name and address of person who	completed use of o	leath (Item 23a) (Type	e, Print)		- ,	, ,			
		Me Crowiey,	NI	610 Du	Idmans 1	ane, Eo	ston, 1	ND Z	21601		
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State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	State of Ma		epartment of F Certificate of		Mental Hygie Rag.		11402
	Physic /Medi		1. Decedent's Name (First, Middle, Las	JEAN	CREI	GHTON			Day Year 22 2007	3. Time of Death
	Exami		4a. Facility Name (If not institution, give		V.C.	4b. City, Town, o	r Location of Death	IIII KCII	4c. County of Deatl	
	Funeral Director		5. Social Security Number 6. Security Number 218-20-7304	# 203 P1 TA 1X 7. Age	(In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth 0//22/19	9. Birth Co	hplace (State or Foreign untry) MD
g			Usual Residence of Decedent		10a City Tava					
laryla	ehov	5	10a. State 10b. County MD KENT		10c. City, Town					10d. Inside City Limits 1 ☐ Yes 2 No
the ⊼	28a-1	rect	10e. Street and Number		WORI	10f. Zip Code		100	Citizen of What Co	
with	3a or	D	10737 HORSESHOE I	LANE		21678			USA	y.
d 21215-0036 filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: or items 23a or 28a-f ehow important: If item 27 is marked other then "naturel", or items 23a or 28a-f ehow any injury or other treumatic event, the Medical Examinar must be notified at ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 N N If Yes, Give Year or Dates:		13. Was Decedent of Hif Yes, specify Cub.	dispanic Origin? (Si an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: WH	
2 P	natur	sted	15. Decedent's Edi (Specify only highest grad	ucation	16a. D	ecedent's Usual Occup	pation	168	b. Kind of Business/l	industry
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	lygie ther t	S	17. Father's Name (First, Middle, Last)		SE	AMSTRESS	19 Mothor's Nam	e (First, Middle, Maid	LOTHING	
and be dependent	ked o	To Be	WILLIAM CHARLES N	ŒNCH				ENTON	den dumame)	
, Maryland and 2 should be file	ulth and Mi 27 is marl r treumati	F	19a. Informant's Name/Relationship (7) FITZGERALD CREIGH			Mailing Address (Street 737 HORSESI				ïp Code)
more	nent of Hea int: If item iry or othe		20a. Method of Disposition 1 □ Burial 2 ☐ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify,		cemetery,	isposition (Name of crematory or other place EAKE CREMA			Location - City or	
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1	nysician Medical kaminer		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	∍.	191 I				Approximate Interval Between Onset and Death
68760, tificate be executed	physician and s the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of)					
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FdS, F	been signed by the a should be detached f	Ď	Pan II. Other significant conditions co		t not resulting in the	ne underlying cause giv	en in Part I.	23e. Did tobacc		the cause of death?
	ate has page 2	Completed						24a. Was an autopsy performed 1 ☐ Yes 2 ☐	death?	topsy findings available completion of cause of
of Vital Physician: I	certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	/	otions all Don Oth	OF:	th (Check only one)		
	r this aral di	2	1 Yes 2 Alo	1 ☐ Inpatien 28a. Date of Injury (Month, Day		atient 3 DOA	4 Nursing H	ome 5 Residence		ıfy)
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UI ne Hospital or	within 24 hours after of the the Funeral Directompletely filled in by	Medical (29a. Certifier (Check only 2 Medical Exami	sician: To the best of ner: On the basis of and manner stat	examination and/	death occurred at the tin or investigation, in my o	ne, date and place, pinion, death occur	and due to the cause red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the	within 2 To the	Σ	29b. Signature and title of partitles			29c. Licens	e number	29d.	Date signed (Month)	Day, Year)
			30. Name and address of person who co	ompleted cause of de	1/2na	rpe, Print)	2163	5 PAI	JL Don	17HE EMO
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			For State Registrar	State of I	Maryland / [•		f Health and of Death	d Mer		ne () 7	11470
3	Physicia	an	1. Decedent's Name (First, Middle, L Mabel S. Crame)	•					100	Date of Death Month	Day	Year .007	3. Time of Death 4:10 A M
	/Medic Examin		4a. Facility Name (If not institution, g		er)		4b. City, Tow	n, or Location of D		ARCH I	4c. Count	of Death	
		•	Calvert Manor H	Healthcare	e Center			ing Sun			Ce	cil	
	Funeral Director		192-12-6876	Sex 7. 1 □ M 2 🔏 F	Age (In yrs. last bii 97	rthday) Yrs.	If Under 1 Yo Months Da		Ain.	Date of Birth (Month, Day, Y ay 20,	9ar) 1909	Coui	olace (State or Foreign otry) Sylvania
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Lo	cation					1	0d. Inside City Limits
	Mary a-f sh lifed	tor	Maryland Cec	il	Ris	sina	Sun						1 Yes 2 No
	or 28)ire	10e. Street and Number				10f. Zip Cod			100	. Citizen of	What Cour	ntry?
	ath w	rail	1881 Telegraph					21911			USA		le di
	ter de Items Irer	Funeral Director	11. Marital Status1 ☐ Never Married2 ☐ Married	12. Was Decede Armed Force 1 Tes 2	s?	13. V	Vas Decedent f Yes, specify (of Hispanic Origin? Cuban, Mexican, Pi	? (Specify uerto Rica	Yes or No- an, etc.)		ce - Americ ck, White,	
2-003e	urs af el', or Exam	by	3 ₩ Widowed 4 □ Divorced	If Yes, Give Year or Date	•	1	I□Yes 2【Ω	No Specify:			Specia	^{fy:})hite
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yland	o d a b	To Be	Leopold Stopfe	r				Anna	ı Gri	punse			
<u> </u>	s ma		19a. Informant's Name/Relationship		198	o. Mailin	g Address (Str	reet and Number of			City or Town	, State, Zip	Code)
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מ	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		21. Signatur Taneral Service Lic	M(X)	L	Ř	T. F	drøss of Facility Pard Fune Queen Str	ral	Home, F	· A .	un a	1011
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Õ	leath certificate be executed attending physician and I for use as the buriat-transii	e	IF FEMALE:								-		
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5	tel or s atte el Dir	Certification:	4 _ Homicide	bullaing	etc. (Specify)					City of Yown,	State)		
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	the thin 2, the f	Med	29b. Signature and title of certifier	and manner	stated.		29c. Lie	cense number		290	I. Date sign	ed (Month.	Day, Year)
	To To Con		K Mot				HU	18519		m	ARGY 7		_
	2		30. Name and address if person wh	o completed care	of death (Item 23a)	(Туре,	Print)	-	_			0,0	
	9		RODNEY DONHA	n, D.D.	1381 TEL	SGR.	APH RO	AD RISIN	45UN	, MD 2	1911		Ė
5.5	Sta		31. Date filed (Month, Day, Year)	32. Reg	of death (Item 23a)	a di		,					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Month **Physician** Day DOROTHY DURBIN 04 05 2007 0045 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Jun 10, 7. Age (In yrs. last birthday, **Funeral** 9. Birthplace (State or Foreign Country D Months 1 ☐ M 2 ☐ F Director 218-34-4438 72 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar mount has a contract the contract of th 10b. County 10c. City, Town or Location 10d. Inside City Limits Cumberland MD Allegany M⊓Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 212 West Oldtown Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white ۵ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 own home homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary C. Harbaugh Lechliter Paul F. Lechliter, Sr. P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 212 West Oldtown Road Cumberland MD 21502 Carl Durbin son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 4/7/2007 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of uneral Service License ^{22. Name} and Address of Facility Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Art 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death stag Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Dav 4□Pregnant at time of death 5 Other (specify) is been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2. No I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

within 24 hours a

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

DAISRAND, TI VIII

VIRGINIA

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended, #71 - State or 17, Pha 3/30/07, pha Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear Mary Baker Drewrey **Physician** 12:30p 2007 22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 222 Tyler Avenue St. Michaels Talbot If Under 1 Year | If Under 24 Hrs. | 8. | Months | Days | Hours | Min. | Date of Birth (Month, Day, Year) 12-27-1909 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 🏋 🗆 F 431-22-2981 97 98 Director Columbia, SC Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahov tra Medical Examiner must be notified at Md Talbot St. Michaels 1 ☐ Yes X ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 222 Tyler Avenue 21663 USA death Funerai 14. Race · American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status hours efter 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 🏖 No Specify: \$ 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Health 11 years Registered Nurse years 17. Fathers Name *(First, Middle, Last)* Robert Edward Lee Pitt William Howard Pitt permit. Peges 1 and 2 should be file Depertment of Haelth and Mentel Hy Important: If item 27 is marked ofth any injury or other traumatic avent, 8008. 18. Mother's Name (First, Middle, Maiden Sumame) Be Sarah Howard 19a. Informant's Name/Relationship (Type, Print)

Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Margaret Broach 222 Tyler Ave., St. Michaels, Md.21663 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Capitol Crematory 3-23-2007 Dover, De. 21. Signature of Funeral Service Licensee R. Carroll Hurley Funeral Home, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of): Examiner INFEGTED FOOT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the ettending physicien end d be deteched for use as the burlei-trensit The law requires that the death certificate be execu Due to (or as a consequence of): of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No 9☐ Unknown 9 I Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 € No To the Hoapital or Attanding Physician; within 24 hours efter death.
To the Funeral Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No P 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Oescribe how injury occurred 27. Manner of Death Certification: Division Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation М 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medies Examiner: On the basis of examination and/or investination in my spinion death. 29a, Certifier cai Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0057908 3/22/07 tilleene my Y aus 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Talbot St., St. Michaels, Md.21663 Robert J. Patterson, MD 800 S. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 2 3 2007

		1. Decedent's Name (First, Middle	e, Last)							2. Date of De Month	ath Day	y Year	3. Time of Dea
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And a second	7	Hegistrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death					
Physic	ian	Jon Evan Del Russo			0, 2007 2:00 P. M					
/Medi		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location o	Death	4c. County of Death					
Exami	ner	38 G Ridge Road	Greenbelt		Prince Georges					
		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year if Under 2	4 Hrs. 8. Date of Birth Min. (Month, Day, Y	9. Birthplace (State or Foreign Country)					
Funeral Director			rs. Months Days Hours	Dec. 27,	1946 New Jersey					
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ld be ental ked	To B	Alfred Michael Del Russo	Jan		wood					
shou mar mat			Mailing Address (Street and Numb							
od 2 :		Barbara Ann Eldridge Crammer/Wife 3	8 G Ridge Road,	Greenbelt, MD	20770					
permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other once.		20a. Method of Disposition 20b. Place of cemeter	Disposition (Name of v. crematory or other place).		0c. Location - City or Town, State					
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it. P		21. Signature of Funeral Service Licensee	22. Name and Address of Facil	y Columbia Mo	rtuary Services, Inc.					
permit. Departn Importa any Inju		1 Xutz Gala	P.O. Box 58007	Washington,	D.C. 20037					
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of Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be or	Ba	Hospital:	utpatient 3 DOA Other: 4 1	lursing Home 5 - Teside	ence 6 ☐Other (Specify)					
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dling F After funer	غ ا	1	Injury Work? M 1 ☐ Yes 2[□No						
Attending r death. Sector: Afte oy the fune	100	2 Acuident 3 Suicide 6 Could not be determined	arm, street, factory, office	28f. Location (Si City or Town	treet and Number or Rural Route Number, n. State)					
pital or Attending Physician: The uurs after death. eral Director: After this certificate hi filled in by the funeral director, page	Cortification.	4 Homicide determined building, etc. (Specify)		Sky St. Form						
plta ours era			ge, death occurred at the time, date	and place, and due to the c	cause(s) and manner as stated.					
Hos 24 hc Fun	Modioal	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge (Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.	ind/or investigation, in my opinion, o	eath occurred at the time, o	uate and place, and due to the cause(s)					
£ € £ €	1808	29b. Signature and title of certifier	29c. License numbe		29d. Date signed (Month, Day, Year)					
With To 1		1 12-11 Charte 20	H00,5	3827	Havel 27. 200					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | State
Registrar AMEND#10fperFH3/28/07, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year LILLY MARY DEWTON MARCH 24, /Medical 2007 8:30 Р 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5400 VANTAGE POINT ROAD #1215 COLUMBTA HOWARD 7. Age (In yrs. last birthday) If Under 1 Year Months Days Social Security Number 6. Sex If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Hours Min. 1 □ M 2 🖾 F Director 137-16-6334 94 MAY 21, 1912 AUSTRIA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or itams 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits 1 ☑ Yes 2 ☐ No MARYLAND HOWARD COLUMBIA Direct 10f. Zip Code 21044 10e. Street and Number 10g. Citizen of What Country? 5400 VANTAGE POINT ROAD #1215 Funeral U.S.A. deeth 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ☐Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No ۵ If Yes, Give 22 Year or Dates: Specify: Specify: 3 Nidowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than rmit. Pages 1 and 2 should be filed w spartment of Health and Mental Hygien portant: If Item 27 is marked other tilly injury or other traumatic event, ID. PHOTOGRAPHER PHOTOGRAPHY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ BERTHOLD BING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUTH DEWTON/DAUGHTER 9405 CLOCK TOWER LANE, COLUMBIA, MARYLAND 21046 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1
☐ Burial 2
☐ Cremation 3
☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING DAVID MEMORIAL GDNS. | 03/27/2007 FALLS CHURCH, VIRGINIA permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dep. HINES-RINALDI FUNERAL HOME, HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition nset and Death **Physician** NEUMONIA Ryc resulting in death) /Medical Due to (or as a consequence of) Examiner Deceverative Dementin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a cons uence of): Examine death certificate be executed the attending physicien and the for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) P.O. ☐ Yes 2 XNo be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, LISEOSE been si should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No of Vital 2 🔯 No etter death.

Director: After this certific in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 0 tilled 24 hours e 1\(\tilde{\text{L}}\) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 ţ 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 20 March 26, 2007 0 30. Name and address of p son who completed cause of death (Item 23a) (Type, Print) JERRY LEVINE, M.D., 11055 LITTLE PATUXENT PARKWAY, COLUMBIA, MARYLAND 21044 31. Date liled (Month, MAR 28 32. strar's Signature State

DHMH 17 Rev 1/2001

Registrar

For	State of Maryland / Department of Health a
1 - For State Registrar	Certificate of Death
1. Decedent's Name (First, Middle, Las	

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	Reg. No.		
2.	Date of Death	3.	Time of Death

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4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death HYATTSVILLE 6901 FARRAGUT STREET PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. 12-13-1943 9. Birthplace (State or Foreign 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ F Months WASHINGTON, DC Yrs. 578-58-6277 63 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location ehow in than "natural", or Items 23a or 28a-f show the Medical Examiner must be nutified at 1 Yes 2 □ No Director MD PRINCE GEORGE'S HYATTSVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code With 6901 FARRAGUT STREET 20785 U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 NDivorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT 12th SOCIAL WORKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental and Mental GILBERT STOKES KATHLEEN JOHNSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) If Item 27 6901 FARRAGUT STREET HYATTSVILLE, MD 20784 KEITA DENNIS/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages nent of h ö Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or once. RESURRECTION CEMETERY 3-28-2007 CLINTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785) . l Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List any one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician BREAST CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading 12 immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of] Examiner certificate be executed Due to (or as a consequence of): burial-Division of Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE esn 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ō Month Day Year 4☐ Pregnant at time of death 5 Other (specify) detached the þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? The law requires 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No page 2 No No certificate 1 Yes 2 X No 25. Was case referred to medical director Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Yes 2 No this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: / 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide hours after ŏ To the Hospital within 24 hours a To the Funeral I completely filled illed 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier Suc D18219 MARCH 23, 2007 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN STAAL 1221 MERCANTILE LAND LARGO, MARYLAND 20774 M.D.

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State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician March ,200 0 /Medical City: Town or Location of Death 4c. County of Death (If not institution, give street and number) Examiner ish attle 105 DICO omico Cir If Under 1 Year If Under 24 Hrs. 6. Sex B. Date of Birth (Month, Day, Year)
Dec.31, 1934 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🔀 F Virginia Yrs. 230-42-2044 Director Usual Residence of Decedent death with the Maryland 10h. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show be notified at 1 ☐Yes 2 No Director Ocean Pines MD Worcester 10g. Citizen of What Country? 10f, Zip Code 10e Street and Number 'natural', or items 23a or USA 8 Garrett Drive 21811 must Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No \$ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie Gillespie Jesse Callaghan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Garrett Dr., Ocean Pines, Md. 21811 Clifford H. Drye 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【☐ Cremation 3 ☐Removal from State 04-02-2007 Frankford, DE 4 □ Donation 5 □ Other (Specify) Cape Henlopen Crem. 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St., Berlin, Md. 21811 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown 9 Unkno Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 2 No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes Z No 1 Impatient this Date of Injury (Month, Day Year) e Hospital or Attending Pt 24 hours after death. e Funeral Director: After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cau se of death (Item 23a) (Type, Print) Po Box 1733 BA 10 ocheel 0028/11 egistrar's Signature 31. Date filed (Month, Day, Year) State MAR 29 2007

DHMH 17 Rev 1/2001

Registrar

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Baltimore, permit. Pages I at Department of Hee Important: If ite	ľ		nd Address of Facility	eral Home	- P A	
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Ox 68' eath certifi attending for use as	iciai	past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (S)		,,,,,,	4	
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To t With To t	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d Date signed (Mor	
		La sha Me en WD	O.C.M.E.		April 3, 2007	
		30. Name and address of person who completed cause of death (Item 23a)				
			Street, Baltimore,	MD 21201		
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			for State Registrar	State of Marylan		tificate c		,	Reg. No.					
	n 8	ş	1. Decedent's Name (First, Middle, La	ist)				2. Date of Dea	ith 🤈	M /	3. Time of Death			
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€ co A Constant Abo	Funeral Director		579-24-4558	Sex 1 □ M 2 🖾 F 7. Age (In yrs. 1	Yrs.	Months Da		(Month, Day 01-24-	1926	Delaw	ce (State or Foreign are			
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	n the	irec	10e. Street and Number			10f. Zip Cod	e		t0g. Citizen of	What Country	/?			
	23a c ust be	lai [12049 Bullwhip			206			U.S.A					
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1	1	□Yes 2🛛	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No <i>Specify</i> :			ce-American ck, White, etc	2.			
5-0	72 ho 'natu dical	etec	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Deced (Give)	ent's Usual Ockind of work do	cupation ne during most of worl tired)	king	16b. Kind of E	usiness/Indu	stry			
121	within ane. than f	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		oo NOT use re ewife/M			Own 3	Home				
2	Hygie Theri		6 17. Father's Name (<i>First, Middle, Last</i>	t)	поиѕе	ewile/h	18. Mother's Nam	e (First. Middle.						
Maryland	ld be ental ked o	To Be	Noble Downes	,			Annie 1			,				
ary	shou and M s mar	-	19a. Informant's Name/Relationship ((Type. Print)	19b. Mailin	g Address (Str	eet and Number or Ru	ral Route Numbe	r, City or Town	, State, Zip C	ode)			
Σ̈́	and 2 salth a 127 is er tra		Mary Flanagan -	Daughter	12290) Catal	ina Drive,	Lusby,	Maryla	nd 206	57			
ore	ges 1 at of He If Item		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	18emoval from State	Place of Dispos emetery, cren	sition (Name of natory or other	place)	Date	20c. Location	- City or Tow	n, State			
Baltimore,	Pag ment ant: I		4 □ Donation 5 □ Other (Special		orge Was	shington	Cemetery 3/	27/2007	Adelph					
Salt	permit. Depart Import any Inj once.		21. Signature of Funeral Service Lice	hsee			dress of Facility				ore Ave.			
	₫ O = @ O		+ownt	/ay			Funeral Ho							
			23a. Parth. Enter the disease, or comshock, or heart failure. List only	- 1	^			or respiratory an	rest,	i i	pproximate nterval Between Onset and Death			
	Physician /Medical		Immediatal Cause (Final disease or condition resulting in death)	ease or condition										
	Examiner			Due to (or as a consequ	uence of):	/				d				
	<u> </u>	er	Sequentially list conditions, if any leading to immisurate	b. Due to (or as a consequ	uence of):									
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.										
o,	icate be executed physician and sthe buriat-transit	Exa	resulting in death) Last	Due to (or as a consequ	uence of):									
68760,	ate be hysici the bu	lical		▲ d										
	ertifica ling pl	Med	IF FEMALE:	22 1/2						I				
N. O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3□	Ectopic pregna Other (specify				ate of delivery onth D	ay Year			
EVELYN ords, P.C	s that ned b	by Pł	Part II. Other significant conditions	contributing to death but not resu	ulting in the un	derlying cause	given in Part I.	23e. Did to	bacco use con	tribute to the	cause of death?			
EVE	quire; en sigi uld be							1 🗆 Y	'es 2 No	3 ☐ Probab	oly 4 □Unknown			
EDMISTON LIDA EVEL sion or Vital Records,	aw re s bee 2 sho	Completed						24a. Was a		Were autops	y findings available			
	The I	mo							med?/ 2 No	death?	letion of cause of □ No			
N/ita	slan: ertifica ctor, l	Bec	25. Was case referred to medical examiner?			,	26. Place of Dear							
TO V	Physician: r this certificaral director, I	인	1 ☐ Yes 2 No		ER/Outpatient	3 DOA		ome 5 Resid	lence 6 🗆 Ot	ner (Specify)				
A C	Ing P		27. Manner of Teath 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		njury at Work?	28d. Describe h	ow injury occu	rred				
EDMI Division	ttend leath stor: , the f	Certification:	2 Accident investigation 3 Suicide 6 Could not b	De 200 Place of injury. At he	omo farm etre		Yes 2 No	20f Loonting (C		· · · · · · · · · · · · · · · · · · ·	2 4 81 6			
N N	after a	ertif	4 ☐ Homicide determined	building, etc. (Specify	y)	et, factory, offi	ce	28f. Location (S City or Tow	n, State)	per or Hurai F	toute Number,			
_	spital ours neral		29a. Certifier Certifying Pl	hysician: To the best of my kno	wledge, death	occurred at th	e time, date and place	and due to the	cause(s) and m	anner as stat	ed.			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune.	Medical	(Check only 2 ☐ Medical Examone)	miner: On the basis of examina and manner stated.	tion and/or inv	estigation, in r	ny opinion, death occu	rred at the time,	date and place	, and due to t	ne cause(s)			
	To th within To th comp	Me	29b. Signature and title of contifier			-	ense number		29d. Date signe	ed (Month, Da	ıy, Year)			
			1/1/1/	MO		Do	062937	/	MARCH	23,	2007			
00	(2)		/ / //	completed cause of death (Item										
UL							AND 20650							
	Sta Registi	_	31. Date filed (Month, Day, Year) MAR 2 8 2097	32. Registrar's Signa	Mile Ste									

			Please Type or Print in					_	
			State of Maryla				Mental Hyg	iene	
			1 - State Registrar		Certificate of	Death		eg. No. 200	11481
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last) Byard E. Ellio	, #			2. Date of Deat Month	27,200 Year	3. Time of Death 7 /// O M
	Examin	er	9a. Facility Name (If not institution, give street and number)	. 1.0	4b. City, Town, o	Location of Death		4c. County of Dea	
	Funeral	- A		yrs. last birtho		If Under 24 HrsV	8. Date of Birth	9. Bir	thplace (State or Foreign
ŀ.	Director		218-20-8664	Yr	s. Months Days	Hours Min.	8/20/19	rear) Co	aware
	yland how at			City, Town o	or Location				10d. Inside City Limits
	e Mar 3a-f sl	Director		alisbur	cy				1 X Yes 2 □ No
	be filed within 72 hours after death with the Maryland ttal Hyglene. od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		10e. Street and Number 912 S. Division St.		10f. Zip Code 21804	l .	10	Og. Citizen of What Co USA	ountry?
	death	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U.S.	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp	pecify Yes or No-	14. Race - Ame	
30	s after ", or ite	by Fu	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:	o rican, etc.)	Black, White	hite
215-0036	2 hour	ted t	15. Decedent's Education	16a. D	ecedent's Usual Occup	ation		16b. Kind of Business	
213	thin 7; e. an "n Medi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(G	Give kind of work done ife. DO NOT use retired	during most of world)	king		
7	filed within Hygiene. Ither than "	S	9 –	Gai	rment cutte			Gant Shirt	Factory
land	uld be fi Aental H rked otl tic ever	To Be	17. Father's Name (First, Middle, Last) Norman Alexander Elliott				ne (First, Middle, M llen Hea	The state of the s	
Mary	nit. Pages 1 and 2 should be artment of Health and Menta ortant: If Item 27 Is marked injury or other traumatic ev e.	-	19a. Informant's Name/Relationship (Type. Print) Jane Church Elliott/wife	19b. N	Mailing Address (Street 12 S. Divis	and Number or Ru sion St.,	ral Route Number, Salisbu	City or Town, State,	Zip Code) 04
saitimore,	Pages 1 a nent of Hea int: If Item iry or othe		20a. Method of Disposition ↑ Disposition ↑ Disposition ↑ Disposition ↑ Disposition ↑ Disposition ↑ Disposition ↑ Disposition ↑ Disposition ↑ Disposition	Nicomi	isposition (Name of crematory or other plac CO MEMORIA	ge) 3/31		20c. Location - City or Salisbury	
galt	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service Licensee	Park	22. Nama and Address				Association 1804
			23a. Part1. Enter the disease, or complications that caused the d	FSP leath. Do not					Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Pros	etate (ancer			Onset and Death
AS.	/Medical Examiner		resulting in death) Due to (or as a cons		:				
Ŀ		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence of)	:				
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a constitution of the constitution of th	sequence of					
2,00,		-	d	sequence or,					
200	ertifica ing ph e as th	Med	IF FEMALE:						
.O. BOX	iaw requires that the death certificate be ex as been signed by the attending physician 2 should be detached for use as the buria	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome pf pre 1 Live birth 2 Ferginant at time 9 Unknown	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	/		23d. Date of de Month	livery Day Year
7	s that t ned by e detac	by Ph	Part II. Other significant conditions contributing to death but not	resulting in the	ne underlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
vitai Records,	equire en sig ould b	ted b	Sclevoderm				1 □ Y€	es 22 No 3□P	robably 4 □Unknown
ec C	e 2 sh	Completed					24a. Was ar autops	y prior to	utopsy findings available completion of cause of
<u>a</u>	sician: The lav certificate has rector, page 2:		25. Was case referred to medical					No 1 ☐ Yes	275 No
>	ysician: is certific director,	To Be	examiner?	2 ER/Outp	atient 3 DOA Oth	or:	th (Check only one	e) ence 6 □Other (Spe	r acihi)
0 0	Attending Physician: r death. ector: After this certific by the funeral director,		27. Manner of Death 17. Natural 5 Pending (Month, Day Year 2 Accident investigation	28b. Tin	ne of 28c. Injur			w injury occurred	outy)
DIVISION	or Atter after deal Director in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - A building, etc. (Sp.				28f. Location (St. City or Town	reet and Number or R , State)	ural Route Number,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Co	29a. Certifier (Check only one) CertifyIng Physician: To the best of my. (Check only one) Amount on the desired manner stated. (Check only one)	knowledge, on and/	death occurred at the til or investigation, in my o	me, date and place opinion, death occu	, and due to the carred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the vithin comple	Me	29b. Signature and title of certifier		29c. Licens	e number	29	9d. Date signed (Mon.	th, Day, Year)
)	100		and Elle	Com	Da	16278		3-27-0	7
	1/2		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)	13 Se	2/15/	MD 218	07
	s. Sta		31. Date filed (Month, Day, Year) 32. Registrar's S	gnature))	7	
Di i	Registr	_	MAR 2 9 2007 Server	K	book				
υHI	MH 17 Rev 1/2	JU1	<i>*</i>		ORIGINAL				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Deborah April Franko 6, 2007 11:45am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1601 Berry Rose Court, Unit F Frederick Frederick 6. Sex 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🕅 F 5/7/1953 213-50-8318 53 Director Morocco Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 NYes 2 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? death with r than "natural", or items 23a or the Medical Examiner must be USA 1601 Berry Rose Court Funeral Apt 21701 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond L. Barrie ပ Dolores Traverse 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary J. Franko Husband 1601 Berry Rose Ct Frederick, MD 21701 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/9/2007 | Smithsburg, MD Smithsburg Crem. 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service Licens M01176 1106 East Church St. Frederick. 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arteriosclerotic Cardiovascular Disease Years /Medicai Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-transi and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical law requires that the death certificate IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 X Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform certificate Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA r To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical c: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D37197 April 6, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan H. Rohrer, M.D., 15 West Seventh Street, Frederick, Maryland 21701-4501 32. egistrar's Signature 31. Date filed (Month)

Registrar

State

2007

			1 - State of Ma State Registrar	-	artment of Health tificate of Deat			ene g. No. 200	7 11482
	Physici /Medic		1. Decedent's Name (First, Middle, Last) JULIA E. FERRO			2	Date of Death Month APRIL	2, 2007	3. Time of Death 12:00P M
9	Examin		4a. Facility Name (If not institution, give street and number) BEVERLY LIVING CENTER		4b. City, Town, or Location			4c. County of Dea	ath
	Funeral Director			(In yrs. last birthday) 90 Yrs.	Months Days Hour	der 24 Hrs. g	Date of Birth 12/1/19	9. Bii 16 V I	nthplace (State or Foreign ountry) RGINIA
	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or iteme 23s or 28e-f show umatic event, the Medical Examinations to multiple at	Director	MD WASHINGTON	10c. City, Town or Lo	STOWN				10d. Inside City Limits XX Yes 2 □ No
	23a or 2	ral Dir	10e. Street and Number 750 DUAL HIGHWAY		10f. Zip Code 21740		10	g. Citizen of What C	ountry?
980	ours after dear rel', or iteme	by Funeral	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced 12. Was Decedent Endmed Forces 1 1 Section	D 1	Was Decedent of Hispanic f Yes, specify Cuban, Mexi I ☐ Yes 20 No Speci	can, Puerto Ri	ify Yes or No- can, etc.)	14. Race - Am Black, Whi	
Baltimore, Maryland 21215-0036	within 72 hours ene. then "neturel", re Medicel Exe	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	(Give	dent's Usual Occupation kind of work done during m DO NOT use retired) HOMEMAKER	nost of working	1	6b. Kind of Business	,
/land 2	should be filed within and Mental Hygiene. marked other than 'matic event, tra Me	To Be Co	17. Father's Name (First, Middle, Last) ROY B. CARTER		18. Mo	other's Name (First, Middle, M ROBERT	aiden Sumame) S	
, Mar	es 1 and 2 should of Health and Me i Item 27 is mark r other treumatio		19a. Informant's Name/Relationship (Type, Print) DAWN EVERSOLE/GRANDDAUGHTER	P.0.	ng Address (Street and Num BOX 1385, N				Zip Code)
timore	Page nent int: fi		20a. Method of Disposition 1	PLEASANT COM	natory or other place) EW ORY GARDENS	APRIL 5, 2007		oc. Location - City o	URG, WV
Bai	pernat. Departr Importe any nje		21. Signature of Funeral Service Licensee	22	Name and Address of Fa	cility BROW [., MART]	N FUNER INSBURG, I	AL HOME, √V 25402	P.O. BOX 821,
8760,	Physician Medical Physician and Physicia	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events	consequence of): consequence of): consequence of):	er the mode of dying, such		respiratory arre	st,	Approximate Interval Between Onset and Death 5 YROW
9	The law requires that the death certifica sie has been signed by the attending ph. page 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti	Petal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	slivery Day Year
rds, P	quires thain signed tuild be det	۵	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause given in Pa	urt I.			to the cause of death?
al Reco		Completed				 _	24a. Was an autopsy perform	24b. Were a prior to death?	utopsy findings available completion of cause of
Division of Vital Records, P.O. Box	To the Hospitel or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certifics completely filled in by the funeral director, is	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatien 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 4 Homicide determined	Year) 28b. Time of Injury	t 3 DOA Other: 4 2 28c. Injury at Work? M 1 Yes 2	Nursing Home 28	d. Describe ho	nce 6 Other (Sp. w injury occurred	
٥	Hospitel c 24 hours ef Funeral D stely filled in	edicai Cer	29a. Certifier (Check only one) Certifying Physicien: To the best of 2 Medical Examiner: On the basis of eand manner state	examination and/or inv	n occurred at the time, date vestigation, in my opinion, o	and place, and death occurred	d due to the ca	use(s) and manner a te and place, and du	is stated. le to the cause(s)
	To the within To the comple	Med	29b. Signature and title of certifier Lauren g Hay		29c. License numbe			d. Date signed (Mor	
	\\		30. Name and address of berson who completed cause bilder AN 2 AR - 2 SHAD	ath (Item 23a) (Type, 21 - 36 8	Print) nullel St	reil-1	Lageste	ru 191)2/740
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar APR 1 1 2007	r's Signature	v				

Certificate of Death

2. Date of Death

Month

Day

Year

Montgomery

Race - American Indian, Black, White, etc.

Alexandria, Virginia

2007

4c. County of Death

10g. Citizen of What Country?

USA

SpecifWhite

16b. Kind of Business/Industry

. Decedent's Name (First, Middle, Last)

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No

3. Time of Death

10:20 P_M

Birthplace (State or Foreign Country)

Journalism

MD 20901 Approximate Interval Between Onset and Death

2 Years

10d. Inside City Limits 1 ☐ Yes 2 XNo

Oregon

Other: XM Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🔀 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29c. License number d60089

March 27, 2007

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13975 Connecticut Avenue, #202, Silver Spring, MD 20906 Ramani Reddy, M.D.

State Registrar

Medical

31. Date filed (Month, Day, Year)

4 ☐ Homicide

29b. Signature and title of certifier

29a. Certifier

2907 MAR 28

ally



DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

MAR 2 8 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No.-3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 4:40P Eileen Guilday April 2007 Mary /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll Mt. Airy 10 Park Avenue 8. Date of Birth (Month, Day, Year) June 17,1933 If Under 1 Year _ If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2**X** F Yrs. 73 New Jersey Director 151-24-1874 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f sh notified 1 X Yes 2 No Directo Mt. Airy Carroll Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be I U.S.A. 21771 10 Park Avenue death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White چ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home 12 homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert J. Baird Alvina Frances DePuy ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mt. Airy, MD 21771 10 Park Ave. William L. Guilday/ husband Department of Heal Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) County Cremation 4/11/2007 22. Name and Address of FacilityHartzler Funeral Home 21. Sign ture of Funeral Service License Sarbler 11802 Liberty Rd. Libertytown, MD 21762 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cerebras 2 weeks /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner and I-transit The law requires that the death certificate be executed Due to (or as a consequence of) physician ar Box 68760, ast attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ NEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2 1 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

within 24 hours after death

To the Funeral Director: A
completely filled in by the f

10 State Ronald E. Miller

29d. Date signed (Month, Day, Year)

4-5-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 Culwell Dr.

Mt. Airy, MD 21771

31. Date filed (Mog Registrar

29b. Signature and title of certifi

32. Registrar's Signature West war

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Lest) Month **Physician** 28 2007 5:10 am GIBSON KATHLEEN ANN March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) **Examiner** Vi<u>lla Rosa Nursing Hom</u>e Mitchellville Prince Georges 8. Date of Birth (Month, Day, Yee If Under 1 Yea 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1 □ M 2 🛣 F Director 140-14-6764 83 June 20,1923 New Jersey Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🔣 No ٧A Funeral Director Fairfax Reston 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code USA 20190 1750 <u>Dressage Drive</u> 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2XX No Specify: Specify: White 2 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Appliances 4 1 2 2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Julia Kloepher ဥ Michael Cavanaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Shaeffer -Daughter Reston, VA 20190 1750 Dressage Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremetion 3 ☐ Removal from State Adams-Green Funeral Home 04/06/07 Herndon, VA 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility

Adams-Green Funeral Home 21. Signature of Funeral Service Licenses 721 Elden St., Herndon, VA 20170 23a. Part1. Enter the parts, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of) Examine j physician and as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) igned by the attending be detached for use as Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings page 2 should 24a. Was an autopsy performed? Completed available prior to completion of cause of death? certificate has 1 ☐ Yes No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 2 No 1 ☐ Yes this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) 29c. License numbe 29d. Date signed (Month. Day. Year) 29b. Signature and title of certifier 2261 30. Name and address of person who co mpleted cause of death (Item 23a) (Type, Print) ALLARGEIS nl 9500 Richamp mo 1 ME. 31. Date filed (Month, Day, Year) APR 1 1 2007 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death A Month Dav Year EDWARD CURTIS GAUTHIER 06:44 AM Dri 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/14/1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Months Days ILLETWOIS 346-12-2891 83 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 💢 No BERKELEY MARTINSBURG 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 176 CUSHWA ROAD 25403 USA 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 No WHITE 1 ☐ Yes 2XXVo Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) DuPONT Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE SUPERVISOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ORA CURTIS ANCEL D. GAUTHIER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARSHA DODSON/DAUGHTER 176 CUSHWA ROAD, MARTINSBURG, WV 25403 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State ROSEDALE CEMETERY MARTINSBURG, W 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, P.O. BOX 821,

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Important: If item 27 is
any injury or other tra

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Baltimore, Maryland 21215-0036

Physician /Medical Examiner

bunial-transit physician the P.0. Division or Vital Records, To the Hospital or Attending Physician: vithin 24 hours after uccu...

To the Funeral Director: After th

327 W. KING ST., MARTINSBURG, WV 25402 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bilatera prevmeni draTea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor Day Month Year 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 100 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Chranic 2 1100 25. Was case referred to examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ∏Yes 2 ∏No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2. Registrar's Signature

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	Funeral Director		5. Social Security Number 6. 409-40-0450 Usual Residence of Decedent	Sex 1 ☐ M 2 💢 F		83 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		9. Bir 923 TN	thplace (State or Foreign ountry)		
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	with t	i Dir	106. Street and Number 107. Zip Code 21660							USA	ourni y r		
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	To the To the Comp	Σ	29b. Signature and title of certifier		Dir	`	29c. Licens	,		29d. Date signed (Mon.	7 0 100		
	/		30. Name and address of person wh	o completed cause	of death (Item) n 23a) (Type,	Print)	09668	15	March 2.	1,2001		
1	6-		Patricialknow	5-AM211		ما 3 ه	Railroad	Ave P.C). Box 122	Goldsboro, M	1021036		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month LOUISE WARD GORFINE March 22 2007 4:37 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis HealthCare - The Pines Easton Talbot | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | May 11, 1908 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2**X**F 98 Director 215-07-6186 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural, or Items 23a or 28a-f show the Medical Examinar must be notified at MD TALBOT ST. MICHAELS Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 WEST CHESTNUT 21663-0188 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ Specify: WHITE 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fit ment of Health and Mental H tant: if item 27 is marked ott jury or other treumatic even WILLIAM HOFFMAN WARD MARIE GETTIER 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JO ANNE FRANKOS/DAUGHTER PO BOX 188, ST. MICHAELS, MD 21663 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Tremation 3 Removal from State permit. Page Department o important: if any injury or once. CHESAPEAKE CREMATION CTR 3/23/2007 STEVENSVILLE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 Joseph m. Ustrowski C.F.S.A 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory at shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Abscess **Physician** Epidural W celes /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, learning to inimitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ate hes been signed by the page 2 should be detached o 9 Unknown 9 Unknown ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Oid tobacco use contribute to the cause of death? Records, á 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24a Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

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'n by the funeral director, pr of Vital Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerei L Medical 29a. Certifier 1 Ccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Gneck only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 42816 23/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Prigt) Richard Burgogne Cynhous SSS 01. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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	/Medic		BETTY F. GEC							Mar		25	2007	10:40 PM	
1	Examir	ner	4a. Facility Name (If not institution, g			4b. City, To			Death			4c. Coun	ty of Death		
	F		Genesis Health 5. Social Security Number 6.		he Pines ge (In yrs. last birthda)		Cast Year		24 Hrs.	8. Date	of Righ		Talbe		
	Funeral Director		220–12–0785	1□M 2 X)F	82 Yrs.		Days	Hours	Min.	(Моп	h, Day, '	Year) 1924		ace (State or Foreign try) T.AND	
	P		Usual Residence of Decedent							200	,	1727	1111(1	ШМР	
	arylar show	Ļ	10a. State 10b. County	7	10c. City, Town or I	_ocation							10	Od. Inside City Limits	
	he Mi	Director	MD TALBOT	L	EASTON									1 X Yes 2 No	
	with t	ă	10e. Street and Number	N T AND		10f. Zip C		11/01			10	g. Citizen o	f What Coun	try?	
	ne 23	Funeral	29443 DUTCHMANS	12. Was Decedent	Ever in U.S. 13	. Was Decede		21601		ify Yes	or No-	14. Ra	USA ace - America	an Indian	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If I tam 27 ie marked other then "natural", or Itame 23a or 28a-f show or other traumatic event, the Medical Examinar mast be notified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces	N o	. Was Deceder If Yes, specifi 1 ☐ Yes 2			, Puerto R	lican, et	;.)		ack, White, e	etc.	
21215-0036	2 hou	ted	15. Decedent's I	Education	16a. Dec	edent's Usual	Occupat	tion			1	6b. Kind of	Business/Ind	ustry	
2	thin 7 e.	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or	life.	e kind of work DO NOT use	retired)	ırıng most	of working	g					
	ed wi	S	12	0	I	IOMEMAK							WN HOM	Œ	
and	2 should be filed within and Mental Hygiene. Ie marked other than aumatic event, than Mental than an aumatic event, than Mental than Menta	Be	17. Father's Name (First, Middle, Las WILLIAM B. HIGO	,					r's Name (SIE I			aiden Suma	ame)		
Ž	should and Men marke	ဥ	19a. Informant's Name/Relationship		19b. Mai	ling Address (Street au					City or Tow	n, State, Zip	Code)	
Ž	alth an 27 le		DARIA BERGER/DAU	JGHTER		443 DUT									
že,	s 1 a of Hei Itam		20a. Method of Disposition		20b. Place of Disp	osition (Name ematory or oth	of er place) l	Da	ite	2	Oc. Location	- City or To	wn, State	
<u><u>E</u></u>	Page ant: If		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		SPRING I	•	-	· I	4/2/	/200	7	EASTO	N, MAR	RYLAND	
Baltimore, Maryland	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 le any injury or other trau once.		21. Signature of Funeral Service Lice	Poush R.f		PELLOWS								IOME PA	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that cause	d the death. Do not er								001	Approximate Interval Between	
ŧ.	Physician		Immediate Cause (Final disease or condition	Regn	noton bus	Time								Onset and Death	
1	/Medical Examiner		resulting in death)	Due to or as	a consequence of):	140		,						10045	
П	⊏xammer	_	Sequentially list conditions,	b. Mal	a consequence of): m Car Crus	eurele	ffile	rens					1	north	
	pe psit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):	2.11. 1	J.	rt:						(Amo.	
	xecut and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):	erru, m	MASS	RIC					0	years	
8760,	cate be executed physician and the burial-transit	dicai E	(d											
9	uficati g phy as the	edic		<u> </u>											
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth		□Ectopic preg	inancv					1	ate of delive	•	
В	e dea the att	sicis	in the past 12 months?	4□Pregnant a 9□ Unknown		Other (spec					_	N	l <i>o</i> nth	Day Year	
<u>α</u>	that the de led by the a detached f	Phy	9 Unknown	a contribution to donate t	and made an archine to the	4-4-		. In Death	-	22-	Didaska				
က်	signed d be det	۵	rait ii. Other significant conditions	contributing to death t	outing to death but not resulting in the underlying cause given in Part I.						3e. Did tobacco use contribute 1 □ Yes 2 □ No 3 □			Probably 4 Unknown	
Š	he law require has been sig ge 2 should b	etec								24-	-				
Ä	he lav e has	Completed								24a.	Was an autopsy performe		prior to con death?	sy findings available apletion of cause of	
<u>e</u>	ifficate or. pa	ပိ	25. Was case referred to medical					OC Diago	of Dooth	10	-	ZNo	1 ☐ Yes	2□ No	
>	Physician: The la r this certificate has ral director, page 2	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpati	ent 2 ER/Outpatie	ent 3 DOA	Other	26. Place					ther (Specify	1	
0	ing Ph ter th		27. Manner of Death	28a. Date of Inju (Month, Da			Injury :					injury occu		,	
<u>S</u>	Attending r death. ector: After by the fune	atic	2 ☐ Accident investigation	on	, , , , , , , , , , , , , , , , , , , ,	М		es 2□N	10						
Division of Vital Records,	i 2 # 0	Certification:	3 ☐ Suicide 5 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of in	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	Hospital 24 hours Funerel etely filled		29a. Certifier Certifying P	hysicien: To the best	of my knowledge, dea	th occurred at	the time	, date and	f place, an	nd due t	the cau	ise(s) and n	nanner as sta	ated.	
	To the Hospital within 24 hours a To the Funerel (completely filled	edicai	(Check only 2 Medical Exe	ominer: On the basis of and manner si	of examination and/or i	nvestigation, ir	my opi	nion, death	h occurred	d at the	ime, dat	e and place	, and due to	the cause(s)	
	To the within To the comple	Σ	29b. Signature and title of certifier	office		29c. l	icense	number	7		290	d. Date sign	ed (Month, L	Day, Year)	
			· /HAN	I / KID			1/2	5455	>			3.2	6.01		
	O		30. Name and address of person who	completed cause of	death (Item 23a) (Type		mp	Class	Lai	(1)	1-0	ASTO.	mA	21601	
1 6	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	ar's Signature	2010	#: 11°	1112	L, In		 	1-100	עיו יי	01001	
	Registr		MAR 2	8 2007	الله معندة	Buch									
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Amend Item State of Maryland / Department of Health and Mental Hygiene 23a per dr., 2006, 04/17/0/dbb Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician George Year March 20 2007 2127 IVICA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospital Baltimore Cit Johns Hopkins 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 220-09-3723 1 M 2 KF 96 Yrs Director 5/2/1910 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f ahow tre Medical Examinar must be notified at 1 Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 408 Virginia Ave. 21801 USA a filed within 72 hours after death in Hygiene.

Other than "natural", or Itema 23. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: δ white 3 ☑ Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Engineering Firm permit. Pages 1 and 2 should be file Depertment of Heath and Mental Hy Important: If item 27 is marked othe any injury or other traumatic avent, 90cs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Emory Frances Disharoon Ruby Ellen Carev ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kristi Possidente/granddaughter 13 Oak Knoll Rd., Cockeysville, MD 21030 20b. Place of Disposition (Name of cometery, crematory or other place)
Springhill Memory
Cardens 20a. Method of Disposition 20c. Location - City or Town, State ty Burial 2 □ Cremation 3 □ Removal from State 4/19/07 4 ☐ Donation 5 ☐ Other (Specify) Hebron, MD ²², Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill kd., Salisbury, MD 21804 Alum of Funeral Service Licensee Tinto 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiop Imonery Arrest Physician 20 minutes /Medical Due to (or as a consequence of): Examiner Chronic Renal Failure Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause, Oisease or injury that initiated events Due to (or as a consequence of): physiclen and s the burial-transit Physicien: The law requires that the death certificate be executed **Urinary Tract Infection** resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ a No 3 Probably 4 □Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cete hes to page 2 s autopsy performed? Yes 2 No certificete 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death | Check only one) examiner? examiner? Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ this 28a. Dare of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No М investigation 3 🗍 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MARC Sowenshine, Medical Octor 165-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

DHMH 17 Rev 1/2001

Bleeve It Specker

Marc Sevenshine The Tohns Ho Liks Horal 600 North Walte Sheet Beltimore Many land 21287
31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 2 8 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}**2007 Physician** Month March 26, Margaret Goodman 8:00 PMM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Citizens Care & Rehabilitation Ctr. Frederick Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/26/1914 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days 1 ☐ M 2 🔀 F Hours 207-26-7457 Director Pennsylvania Usual Residence of Decedent the Maryland or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick ¥XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with r than "natural", or items 23a or the Medical Examiner must be r 2100 Whittier Drive 21702 USA Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2XXNo White þ Specify: Specify: 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 **Florist** Floral Arrange/Sales traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Defrehn Adelena (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Sara Goodman/Daughter-in-law 750 Carroll Parkway, #6A Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State German Prot. Cemetery 3/31/2007 Mahanoy Township, PA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home, PA wre of Funeral Service License 1621 Opossumtown Pike, Frederick, MD 21702 OC 23a. Part Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Couse (Final disease or condition resulting in death) Physician atkeroseli /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for us a consequence off, Examine the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): ending physician are use as the burial Box 68760, Physician/Medical attending IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Day Year 4☐Pregnant at time of death ed by the a 5 Other (specify) P.O. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 2 No 1 🗌 Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 s autopsy perform the Funeral Director: After this certific npletely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 20 No Hospital: Other: ို 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Deal
Natural
Control
Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Division 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical vestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature and title of

30. Name and address of person who complete

Robert Kaufmann

DHMH 17 Rev 1/2001

Frederick, MD 21701

29d. Date signed, (Month, Day, Year)

and manner stated

SÓO W.

8 2007

cause of death (Item 23a) (Type, Print)

9th Street

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Montal Hygi-

			1 - For State Registrar	aryiand / Depa <i>Cei</i>	rtificate of			g. No 0 0 7	493
Н	Physicia	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month	n Day Year	3. Time of Death
	/Medic	al	NELLIE B GUES					24, 2007	8:05 P ^M
1	Examin	er	4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSP	RICK		4c. County of Death FREDERIC	rk		
	Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	1.	place (State or Foreign atry)
	Director		461-50-3773 1□M 2√F	93 Yrs.	Months Days	Hours Min.	Jan. 17,	1914 Nort	h Carolina
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			1	0d. Inside City Limits
	Mary I-f sho fied a	tor	Maryland Frederick	Frederic	k				1 ☐Yes 2 ☐ No
	th the or 28s)irec	10e. Street and Number	1	10f. Zip Code		10	g. Citizen of What Cour	ntry?
	ath wi	ral	713 Fairview Avenue		2170			U.S.A	
	items	Funeral Directo	11. Marital Status 12. Was Decedent Armed Forces? 1 □ Never Married 2 □ Mamed 1 □ Yes 2 1 □ Yes	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
336	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show sdical Examiner must be notified at	þ	3 Widowed 4 Divorced Year or Dates:		1 □ Yes 2 🛣 No	Specify:		Specify: Wh:	ite
5-0036	72 hor	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup	nation	ina 1	6b. Kind of Business/In	dustry
7	be filed within 72 ho ital Hygiene. do other than "natul event, the Medical	mple	Elementary/Secondary (0-12) College (1-4or s	D+)		during most of work d)	9	N	
2	il Hygie other t		17. Father's Name (First, Middle, Last)	Re	egistered	18. Mother's Name	e (First, Middle, M	Nursing Jaiden Surname)	
<u>a</u>	D 9 2 0	To Be	Joyner Harris				Jane Boyd	,,	
aZ	2 should and Men is marke aumatic	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	and Number or Rura	al Route Number,	City or Town, State, Zip	Code)
Σ,	s 1 and 2 shou f Health and M item 27 is mar other traumat		Marjorie L. Joerdens / Dau						
altimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, cren				toc. Location - City or To	own, State
	C 65 -J		4 □ Donation 5 □ Other (Specify) 21. Signature of Funer J Sez ice Licen.		n Mem. Ga 2. Name and Addre	rdens 3/2	26/07 F	rederick, N	Maryland
g	permit. Departimport any inj		Rute	101 120	BERT E. D 1 NORTH	AILEY & S	ON FUNER	AL HOMES, I	7.A.
F			23a. Part1. Enter the disease, or semplications that caused shock, or heart failure. List only one cause on each li	the death. Do not ente					Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	eunzne	1.				Onset and Death
•	/Medical Examiner			a consequence of):		•_			10 yeur
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	cuted id ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Linter Uniderlying Cause (Disease or injury that initiated events	-					
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08/PN	tificate be executed g physician and as the burial-transit	edical	d						
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Ď	death ce e attendir ed for use	hysician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown]Ectopic pregnancy]Other <i>(specify)</i>	<i>y</i>		Month	Day Year
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	iclan: The law certificate has b ector, page 2 sl	ompleted			·		autopsy perform	ed?// death?	psy findings available mpletion of cause of
VITA	lan: rtifical	CO	25. Was case referred to medical			26. Place of Death		Po 1 □ Yes	2 No
) 	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Napatie			er: 4 ☐ Nursing Ho	me 5 Resider	nce 6 □Other (Specif	y)
	ffer ne	ion:	27. Manner of Death 1 Pending (Month, Da	iry 28b. Time of ly Year) Injury	Wor	yat k? Yes 2 ∐ No	28d. Describe how	w injury occurred	
IVISION	Attending r death. ector: After by the funer	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury determined	ury - At home, farm, stre			28f. Location (Stre	eet and Number or Rura	al Route Number.
S	s after al Dire	Certification	4 ☐ Homicide determined building, et	c. (Specify)			City or Town,	State)	·
	Hospit 4 hour Funer ely filli		29a. Certifier 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of	f examination and/or in	occurred at the tir	me, date and place, opinion, death occur	and due to the car red at the time, da	use(s) and manner as s	tated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	one) and manner st 29b. Signature and title of certifier	ated.	29c. Licens	e number	29	d. Date signed (Month	Dav. Year)
	F ≥ F ŏ		Breus & 1/51	Elen Mi	10 1	3049		3/26/7	007
(7	1	30. Name and address of person who completed cause of completed cause of complete cause of ca	leath (Item 23a) (Type,	Print)	/ (d. Date signed (Month,	
	9		Francis E. Becker	10;300	W. FT.	7/1	rede	ruly M.	1 21701
	Sta Registr	te ar	31. Date filed (Month, Day, Year) 32. Poistr AR 2 8 2007	ars Signature	beele				

Registrar

			. For		f Maryland / Dep			•	•	
			1 - State Registrar			ertificate of			.No.	1434
ı	Physic	ian	Decedent's Name (First, Middle, Last	•				2. Date of Death Month	Day Yea	
	/Medi Examir		Harriett Goodman		nber)	4b. City. Town o	r Location of Death	3	31 200 4c. County of De	
	LAdinii	ici	Chestertown Nursin				tertown		Kent	
	Funeral		5. Social Security Number 6. S	9X □ M 2√2 F	7. Age (In yrs. last birthda) 90 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. B	Birthplace (State or Foreign Country)
	Director		241-22-6826 Usual Residence of Decedent	^	90 113.			4-7-19	17 D:	illon, SC
	show	_	10a. State 10b. County		10c. City, Town or I	_ocation				10d. Inside City Limits
	28s-f	Director	MD Queen A	\nne	Milling	ston 10f. Zip Code		100	. Citizen of What (1 Yes 2 No
	h with	I Di	108 Little Glan	odina Ra	vad.		.651	109	USA	country :
	ems 2	Funeral	11. Marital Status	12. Was Dece Armed For	dent Ever in U.S. 13	. Was Decedent of H If Yes, specify Cuba		pecify Yes or No-		merican Indian,
36	be filed within 72 hours after death with the Maryland nat Hygiene. od other then "natural", or Items 23a or 28a-f show event, the Medical Examplear must be mutified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv Year or Da	2 ☐ x No e	1 ☐ Yes 2 ☑ No	Specify:	, , , o.c.,	Specify: W	
21215-0036	72 hou		15. Decedent's Ed	lucation	16a, Dec	edent's Usual Occup	ation	16	b. Kind of Busines	ss/Industry
121	within 7 iene.	Completed	(Specify only highest gra	College (1	-4or 5+)	e kind of work done o DO NOT use retired	auring most of won d)	king		
d 2	ther int.		1.7. Father's Name (First, Middle, Last)	4	Sc	cial Serv		ne (First, Middle, Ma	Social S	Services
an	lid be lental rked o	To Be	Albert Parker					idie David	ŕ	
Maryland	s 1 and 2 should be f f Health and Mental P item 27 is marked of other traumatic ever		19a. Informant's Name/Relationship (7		19b. Mai	ling Address (Street				, Zip Code)
	1 and 1ealth 1m 27 1her t		Jeddie De Cour	sey	20b. Place of Disp	PO Box 286		ertown, M		
nor	Pages nent of I int: if it		1 ⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		State cemetery, cri	ematory or other plac	ce)		c. Location - City of	
Baltimore,	- 문문을		21. Signature of Funeral Service Licen			Cemetery 22. Name and Addres		5-2007	Chester,	. MD
8	Depe Impo eny is		Kirk	elfer	fein	Fellow, H	elfenbei:	n & Newnar	n Cheste	ertown, MD
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that cannot cause on ea	aused the death. Do not el	Dempt	ng, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as a consequence of):					
	B #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (ur as a consequence of).					
	be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.	or as a consequence of):					
760,	ate be executed nysicien and he burial-transit	calE		D00 10 (t	or as a consequence or).					
99	rtificate ng phy as the		IF FEMALE:	u.		2				
Box	feath certificate b attending physic I for use as the b	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1☐Live bi		□Ectopic pregnancy			23d. Date of d	lelivery Day Year
o.	at the de by the a tached f	nysic	1 □ Yes 2 ☑ No 9 □ Unknown	4∐Pregna 9⊡Unkno		Other (specify)			, monar	Say Tour
Δ.	es th	Ď	Part II. Other significant conditions of	ontributing to de	ath but not resulting in the	underlying cause give	en in Part I.	23e. Did tobac		to the cause of death? Probably 4 Unknown
Vital Records,	law requires been so should	Completed						24a. Was an		autopsy findings available
Ä		E						autopsy performer	death?	o completion of cause of ? es 2 No
Vita	Physiclan: this certific al director,	Be	25. Was case referred to medical examiner?	Hospital:		other all post Other		h Check only one		
ō		2	27. Manner of Death	28a. Date o	patient 2 ER/Outpatient 1 ER/Outpatient 28b. Time	ent 3 L DOA	Nursing Ho	ome 5 Residence 28d. Describe how		pecify)
sion	Attending I r death. ector: After by the funer	atlo	1 Natural 5 Pending 2 Accident Investigation		n, <i>Day Year)</i> Injury		k? Yes 2 □ No			
Division	al or Att	Certification;	3 Suicide 6 Could not be 4 Homicide determined	286. Place	of Injury - At home, farm, s g, etc. (Specify)	treet, factory, office		28f. Location (Stree City or Town, S	t and Number or I State)	Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	Medical	29a. Certifier 1 Certifying Phyone) Medical Exam	ysician: To the liner: On the ba and mann	best of my knowledge, dea sis of examination and/or i er stated.	th occurred at the tim	ne, date and place, pinion, death occur	and due to the caus red at the time, date	e(s) and manner and place, and di	as stated. ue to the cause(s)
	To the within 2 To the complete	ž	29b. Signature and title of certifier	29	0.557	29c. License	e number	29d.	Date signed (Mor	nth, Day, Year)
			1 June K	1000	m	Vud.	0/70	36	412/07	
			30. Name and address of person who of Sussin K. Loss ms		of death (Item 23a) (Type	1 3 //	of notom	Nd 21	1620	
	Sta		31. Date filed (Month, Day, Year)	32. Re	trar's Signature	An Ma				-
3.	Registr	ar	APR 04	2007	the state of					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0950 AM oodle rainia 2007 /Medical 4a. Facility Name If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Calver Sin 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Days 1 ☐ M 2 💢 F 169-34 - 563 Usual Residence of Decedent 78 Yrs. BOCTKWYN, PA Director with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "naturel", or items 23a or 28a-f ehow The Medical Examinar must be notified at 1 Yes 2 No Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9363 188 ROAD death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 15-0036 1 ☐ Yes 2 No Specify: þ WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 2121 and Mental Hygiene. HEALTH CARE Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY 12 and 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 8 MARGARET PETERS Peges 1 and 2 should ပ္ 13046 Maryl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 : Department of Health ar Importent: If Itam 27 le 188 HILLTOF OXFORD 600DLEY Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 4 □Donation 5 □ Other (Specify) 21. Signature of uneral Service RUFFENACH 224 PENN AUE OHRORD, PA 19363 MO1170 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, list only one cause on each line. Approximate Interval Between Onset and Death 255. Part1. Enter the dissess shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Physician IN 50. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any learning to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner l or Attending Physicien: The law requires thet the death certificate be executed the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 Ø No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 NO 2 -NO 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 HO 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After t 5 Pending investigation s after dec. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day/Year) 29b. Signature and title of certifier 29c. License number

State Registrar

1

M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

32. Registrar's Signature

Dimonse

Registrar DHMH 17 Rev 1/2001

State

HVNSON

			1 - For State Registrar	State of M	arylan		artmen rtificat			and M		iene g. No.	007	97	
	Physici	an	Decedent's Name (First, Middle, L								Date of Deat Month	Day 25	Year	3. Time of Death	
	/Media	al	JAMES DAWSON HARPER, JR. MAR										2007	8:50AM M	
	Examin	er	WILLIAM HILL H		'		40. City,	EAS		n Death		46. Cou	TAL	вот	
	Funeral	5. Social Security Number 6. Sex 7. Age (In vrs. last birthd							If Under		8. Date of Birth	161	9. Birtho	place (State or Foreign	
	Director		214-12-5213	¾ M 2□F	89	Yrs.	Months	Days	Hours	Min.	8 Date of Birth (Month, Day, DEC 20,	1917	MAR	YLAND	
	pu.		Usual Residence of Decedent 10a. State 10b. County		10c Cit	ty, Town or Lo	ontion							10d. Inside City Limits	
	sho	ō			100.01									1 ☐ Yes 2 ☐ No	
	tha h	ect	MD TA	LBOT		ST. M	10f. Zip				10	a. Citizen	n of What Country?		
	3a or		306 CLEVELAND ROAD 21663									USA	,		
	within 72 hours after death with the Maryland ene. than "natural", or tiems 23a or 28a-f show he Madical Examinat must be indiffied at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U	.S. 13.	Was Deced	ent of Hi			ecify Yes or No- Rican, etc.)		ace - Americ	can Indian,	
9	or the	F.	1 Never Married 2 Married	Armed Forces: 1 Yes 2 1 If Yes, Give			1 ⊡Yes :		Specify:	i, Puerto	rican, etc.)	Spe	lack, White,	etc.	
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:									MH	ITE	
21215-0036	"nat	Completed	15. Decedent's (Specify only highest g	Education trade completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	rk done d	uring most	t of worki	in <i>g</i>	16b. Kind of	Business/In	dustry	
12	withi	mo	Elementary/Secondary (0-12)	College (1-4or	5+)			MER				AG	RICULT	URE	
	il Hygid other	BeC	17. Father's Name (First, Middle, Las	st)		1			18. Mothe	r's Name	First, Middle, A	faiden Surr	ame)		
Maryland	parmit. Pages 1 and 2 should be filed within 72 hours after death with tha Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-1 show appring yor other traumatic event, the Medical Examination and be notified at another.	TOE	JAMES D. HAR	PER, SR.						DA	SEY F.	PRICE			
lar.	2 sho and Is ma		19a. Informant's Name/Relationship				-				al Route Number,				
	1 and Health tem 27 other tr		EURITH F. HARPE 20a. Method of Disposition	R/WIFE	20h F	30 Place of Dispo			ND RI		ST. MICH		MD 21 n - City or To		
altimore,	Pages nent of H int: If Ite		1 Burial 2 □ Cremation 3		. 0	semetery, crer	natory or o	ther place					·		
를	parmit. Page Department of Important: If any injury or once.		* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		SPR	ING HI	LL CE 2. Name an				0/2007	EAST	ON, MA	RYLAND	
Ba	parmi Depa Impo any ii		Joseph M O	strousk C.	F.SI	O FE	LLOWS	, HE	LFENI	BEIN	& NEWNA	M FUN	ERAL H	OME, P.A.	
			200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between												
	Pnysician		Immediate Cause (Final disease or condition	y one cause on cause	1	10/00	4	8	and a com	aaraara'	Tonico			Onset and Death	
	/Medical		resulting in death)	Due to (or as	a conteq	ue ce of):	Cryn.	5	nere!	ărt.vr	_		- 15	1004	
	Examiner		Sequentially list conditions, Sequentially list conditions,									-	مراج		
	ed sit	nine	if any, leading to immediate Court (or as a consequence of): cause. Enter Underlying Cause, (Disease or injury									v			
	be exacuted sician and burial-transit	Examiner	that initiated events c. Due to (or as a consequence of);												
760	death certificate be exacuted e attending physician and id for use as the burial-transit	icalE													
89	tificate g phys as the	ledic		u.								- 14			
Вох	death certifica attending ph d for use as th	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Ectopic pr	9403004				23d.	Date of delive	•	
	e deat he att ed for	sicle	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)			Other (specify)					Month Day Year				
o.	The law requires that the death cer tle has been signad by the attendin tage 2 should be detached for use	Physiclan/Med	9 Unknown	9□ Unknown		. National Constitution		er-lac	-1- 5-41		OZa Didash			he agues of death?	
js,	ires the signal	by	Part II. Other significant conditions	contributing to death t	Jul not res	uiting in the u	rideriying ca	ause give	m in Pan i.		239. Did tob	A.c	o use contribute to the cause of death? 20 No 3 Probably 4 Unknown		
Ö	w require been sign	Completed	Haus												
Records,	has ge 2	ldm	(1000)								24a. Was ar autopsy perform	/	prior to co death?	ppsy findings available mpletion of cause of	
		e Co	25. Was case referred to medical		1 Ye								1 🗆 Yes	2 □ No	
Viital	ysician: The is certificate hidirector, page	0 8	examiner?	Hospital:	ent 2□	ER/Outpatier	t - 3∏ DO	Othe				(Check only one) ne 5 ☐ Residence 6 ☐ Other (Specify)			
סר	무 두 등	ın: T	27. Manner of Death	28a. Date of Inju (Month, Da	ıry	28b. Time of Injury		8c. Injury Work			28d. Describe ho				
Sio	anding l sath. or: After he funer	atic	1 Natural 5 Pending 2 Accident investigati	ion	, ,	,,	М		′es 2 🗆 I	No					
Division of	il or Attanatter deatl	Certification:	3 Suicide 6 Could not 4 Homicide determine		jury - At ho tc. <i>(Specif</i>	ome, farm, str y)	eet, factory	, office			28f. Location (Str City or Town		mber or Rura	al Route Number,	
	To the Hospital or Attano within 24 hours after deatl To the Funeral Diractor: completely filled in by the		29a. Certifier 1 Certifying I	Physician: To the book	of mules-	nulodas d- ::		na ab c si	- dat	1 -1	and due to the				
	Hos 24 hc Fun etely	edical	(Check only 2 Medical Expone)	Physician: To the best aminer: On the basis of and manner st	of examina	ition and/or in	vestigation,	, in my op	e, date an inion, deal	th occurr	ed at the time, da	use(s) and te and plac	e, and due to	tated. the cause(s)	
	To the Ho within 24 t To the Fu completely	Me	29b. Signature and title of certifier		. 4	^	290	. License	number		29	d. Date sig	ned (Month,	Day, Year)	
	. 21.0		▶ Will	lam HT.	orn	4 ANS		DE	1871	>		3	251	67	
	1/1 -		30. Name and address of person wh	o completed cause of	death (Iten	n 22a) (Type,	Print)					/			
-	70	_	WILLIAM H. WOOD	JR., M.D.	501	DUTCHM	ANS I	ANE,	EAS'	CON,	MARYLAN	D 216	01		
	Sta Registr		31. Date filed MAR, 29, 70200	7 2. Regist	rans Signa	iture	a s								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Albert William Hilberg March 26, 11:30 p M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 X M 2 □ F 317-18-0740 84 April 5, 1922 Indiana Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12512 Davan Drive 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼ Yes 2 □ No
If Yes, Give 1947-1 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: þ Specify. 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Pathologist U.S. Government - Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Hugo Albert Hilberg Emily M. Nallenweg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Eric P. Hilberg - Son 1701 Brown Road, Las Cruces, New Mexico 88005 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖺 Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Fort Lincoln Crematory 3/31/2007 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Non 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the dis ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Respiratory Failure Due to (or as a consequence of): Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Stroke Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death Day Year 5 Other (specify) □Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed'

Physician /Medical Examiner

the burial-tran

attending ph

2 should be

page

Be

Certification: To

Medical

25. Was case referred to medical examiner?

5 ☐ Pending investigation

6 Could not be determined

certif

28

30. Name and address of person who complete

Sonja C. Wyche, M.D.

MAR

31. Date filed (Month, Day, Year)

1 ☐ Yes 2 ☑ No

27. Manner of Death

2 Accident

4 Homicide

3 ☐ Suicide

1 X Natural

fureral director,

filled in by

certificate has

To the Hospital or Attending Physician: within 24 hours after death.

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

2X No

2 No

29d. Date signed (Month, Day, Year)

26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 28d. Describe how injury occurred М

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

Injury

29b. Signature and title d 29c, License number D62885

1 🔀 Inpatient

28a. Date of Injury (Month, Day Year)

cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland 20910

State Registrar Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registre Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician JOHN GREGORY** 10:20 P M HLAVATY, JR. MARCH 2007 /Medical 26, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PRINCE GEORGES GENERAL HOSPITAL CHEVERLY PRINCE GEORGES 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Hours 1**X** M 2□ F Months Yrs. Director 304-48-1209 60 MAY 31, 1946 INDIANA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-f ehor other treumatic event, the Madical Examinar must be notified at Director 1 Yes 2 □ No MD. PRINCE GEORGES RIVERDALE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6209 49th AVE. should be filed within 72 hours after death of Mental Hygiene. marked other than "naturel", or items 23. Funeral 20737 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates TTNAM Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 CLERK FOOD INDUSTRY permit. Pages 1 end 2 should be file Deperment of Health and Mental Hy Important: If Item 27 is marked oth eny linjury or other treumatic event 900.8. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **JOHN GREGORY** ဂ္ HLAVATY, SR. CATHERINE BRYAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 58 DEGROFF PL., PARK RIDGE, N.J. 07656 DANIEL D. HLAVATY/BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) CHAMBERS CREMATORY 3-28-2007 RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. MOO091 | 5801 CLEVELAND AVE., RIVERDALE, MD. 20/3/ 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ARRHYTHMIA FATAL CARDIAC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) death certificate be executed attending physician and for use as the burial-transit UNG resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day signed by the a lid be detached for 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Deen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 this certificete has 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification; 28d. Describe how injury occurred 1 MNatural 5 Pending investigation death. 1 Tes 2 No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide To the Hospital within 24 hours 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 58182 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. DONALD GEORGE HOSPITAL 3001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 28 2007 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year Robert E. Henning MARC 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Vicania conter PENINSUM REGIONAL MEDICAL Salisbury If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 □ F Director 091-22-4410 76 8/8/1930 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show notified at 1X Yes 2 No Maryland Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? nt of Health and Mental Hygiene.

If item 27 Is marked other than "natural", or Items 23a or?
or other traumatic event, the Medical Examiner must be n 21826 USA 108 Williams Ave. by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: Army 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 🖫 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify white Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) shipping/receiving IBM Corp 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Erwin Robert Henning Martha Mercer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Williams Ave., Fruitland, MD 21826 19a. Informant's Name/Relationship (Type. Print) Florence A. Henning/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 4/3/07 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 21. Signal re of Funeral Sen Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one of use hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 72 hours if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit death certificate be executed ovones Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 5 Other (specify) P.O. | 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No performedy Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 funeral To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of grifier 29d. Date signed (Month, Day, Year) 3127107 D32212 erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address

Registrar DHMH 17 Rev 1/200

State

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md.

100 E, Carroll St.

32. Registrar's Signature

Keim

Stephen 31. Date filed (Month, Day, Year)